GEHA Connection Dental Federal
P.O. Box 21542
Eagan, MN 55121-9930
Fax: 816.257.3302

Other Coverage Information Form

If you or any other family member have other coverage that pays for your dental expenses in addition to GEHA, please return this completed form to GEHA Connection Dental Federal by mail or fax to the address/number above.

EMPLOYEE OR ANNUITANT IDENTIFICATION DATA

To help us identify your account, please provide the following information. Your ID# can be found on your dental ID card.

(First Name) *(Initial)* *(Last Name)* *(GEHA Connection Dental Federal ID#)*

(Street Address) *(City)* *(State)* *(ZIP Code)*

OTHER GROUP COVERAGE INFORMATION

Are you, or any other covered family member, actively employed any place other than the federal government? ☐ Yes ☐ No
If yes, please give family member's name and employer's name.

(Name of Family Member) *(Name and Address of Employer)*

Are you or any other family members covered under any other group health insurance plan? ☐ Yes ☐ No
If yes, please complete the following.

Policyholder of other plan

Relationship to GEHA Member

Is this other coverage ☐ Single Coverage ☐ Family Coverage

Is this person ☐ Employed ☐ Retired; If yes, Retirement Date

Please provide information about the other carrier.

(Name of Other Plan Carrier) *(Phone Number of Other Plan)*

What is the policy number, contract number or group certificate number of other policy?

Please list family members eligible for other group coverages below.

Effective Date *(Month/Day/Year)*

If terminated, what was the last date of coverage? *(Month/Day/Year)*

If you are enrolled in the Federal Employees Health Benefit (FEHB) Program, what is the name of your FEHB plan? This information can be found on the front of your FEHB plan brochure.

Name of FEHB plan

FEHB Code

SIGNATURE

I certify that the information furnished by me is true and correct to the best of my knowledge and belief.

Member Signature

Date