Preferred Health Plan of the Carolinas
"Health Coverage That Fits"

Date

Name
Address
Address

Group Name:
ID#:

RE: Other Insurance

Please advise if your covered spouse/dependent listed below has other insurance:

1. Spouse name and date of birth:______________________________
2. Dependent(s) name and date of birth: ________________________

Please complete the following questions to prevent delay of claims processing if there is other insurance:

3. Spouse's Social Security Number: __________________________________
4. Name and address of spouse's employer:
   ____
   ____
5. Name, address and phone number of spouse's insurance carrier ***(please include supplemental coverage, Medicaid, Medicare or Tricare):***
   ____
   ____
6. Policy number: _________________________
7. List all dependents covered by your spouse's policy.
   ____
   ____

Thank you for your assistance,

Preferred Health Plan of the Carolinas
PO Box 220397
Charlotte, NC 28222