



Request for Duplicate Coverage Information

If you have dependents covered under you health benefit plan, the following information is required. Please complete this form, sign, date and return it to SBS, Inc at P.O. Box 7777, Lancaster, PA 17604-7777 Fax: (717) 581-8379

Employee Name: _____ Member ID: _____

Group Name: _____ Group No. _____

Date Sent: ____/____/____

1. Are any of your dependents covered under another employee benefit plan?

Yes _____ No _____

2. If "yes", please list the following information:

Name of Other Insurance Carrier: _____

Address: _____

Telephone No.: (____) ____-____

Name of Other Employer: _____

Name of Employee: _____ Plan ID#: _____

Dependents Covered: _____

Effective Date: ____/____/____

Termination Date: ____/____/____

Spouse's Birth date: ____/____/____

Signature: _____

Date: ____/____/____

Please contact out office as changes in this information occur. You may receive subsequent requests from us on a yearly basis. If you have any questions please contact our office.

Notices

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties