



REQUEST FOR DUPLICATE COVERAGE INFORMATION

If you have dependents covered under your 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: _____ S.S.No. _____ - _____ - _____

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: _____ S.S.No. _____ - _____ - _____

Dependents Covered: _____

Effective Date: ____/____/____ Termination Date: ____/____/____

Spouse's Birthdate: ____/____/____

Signature: _____ Date: ____/____/____

Please contact our 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.