Indiana Farm Bureau®
Health Plans

MH-IN-AP-FM20-300

Other Insurance Information

Subscriber Name: _____

Subscriber Identification Number: _____

1) Does any member covered on this policy have other medical or dental insurance?
( ) YES ( ) NO

2) If you answered "YES" to question No. 1, complete the information below:

Name of member covered by other insurance: _____

Employer: _____

Insurance Company: _____

Insurance Company Telephone Number: _____

Effective Date of Coverage: _____

Policy Holder: _____

Relationship of Insured to Policy Holder: _____

Contract/ID#: _____

Coverage type: ( ) Family ( ) Individual ( ) Retired

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3) Are you or any member under your policy covered by Medicare?
( ) YES ( ) NO
If "YES" complete the questions below:

_____ _____ _____
Medicare ID Date of Birth Name

Please check all that apply:	Yes/No	Effective Date	Termination Date
☐ Medicare Part A			
☐ Medicare Part B			
☐ Medicare Part C			
☐ Medicare Part D			

Are you/they disabled? ( ) YES ( ) NO
Do you/they have End Stage Renal Disease (ESRD)? ( ) YES ( ) NO

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4) Is any family member covered by a court decree? ( ) YES ( ) NO
If "YES" complete: Name(s) of child or children: _____
Responsible Party(ies): _____

I certify to the best of my knowledge, the information provided above is true and correct.

_____ _____
Subscriber Signature **Date**

Please return completed form to: Indiana Farm Bureau Health Plans
P.O. Box 1424
Columbia, TN 38402-1424