We Want to Be Ready to Handle Your Claims...

MHBP SM

You can't always know just when you or your family will need medical treatment. But you can take steps now to help make sure things go smoothly. Even if your physician files claims for you, we need to know if you or your dependents have additional health care coverage. We cannot pay any claims until we have this information from you—**please provide it as soon as possible.** You can provide it over the phone, or you can complete and return this form to the address below. If any of this information changes in the future, you should advise us immediately. Please call 1-800-410-7778.

Enrollee Information

Please Print Your Full Legal Name Below (Avoid nicknames and abbreviations) Include title (Jr., Sr., III., etc.) with first name	**Gender** (circle)	**Birthdate** (MM/DD/YYYY)	**Social Security Number**	**Phone Number**
Enrollee Name *(Last)* *(First)* *(MI)*	M F			

Is there a court decree that declares which parent is to provide coverage for any of your covered dependents? ❑ **No** ❑ **Yes**; *Attach a copy of the applicable section of court decree*

Other Coverage Information

Are you or any dependents (including spouse) covered under another health plan or Medicare? ❑ **No**; *Skip this section. Simply sign and date below.* ❑ **Yes**; *Complete this section. Attach additional forms, if necessary. Sign and date below.*

Other Plan #1

Name of Subscriber *(Last)* *(First)*	Subscriber's Social Security Number	Relation to Above Enrollee (circle)	Effective Date(s) of Coverage
		Enrollee (self) Spouse Dependent	
Name of Person(s) Covered *(Last)* *(First)*	**Name of Other Carrier or Medicare**	**Benefit Type(s) (circle)**	**Policy Type (circle)**
		Medical Dental Vision Prescription	Individual Group HMO Medicare CHAMPUS PPO

Other Plan #2

Name of Subscriber *(Last)* *(First)*	Subscriber's Social Security Number	Relation to Above Enrollee (circle)	Effective Date(s) of Coverage
		Enrollee (self) Spouse Dependent	
Name of Person(s) Covered *(Last)* *(First)*	**Name of Other Carrier or Medicare**	**Benefit Type(s) (circle)**	**Policy Type (circle)**
		Medical Dental Vision Prescription	Individual Group HMO Medicare CHAMPUS PPO

Enrollee Signature Date

Please submit this form to:

The Mail Handlers Benefit Plan
P.O. Box 8402
London, KY 40742