

Employee Name \_\_\_\_\_ Company \_\_\_\_\_

**OTHER INSURANCE QUESTIONNAIRE**

**(To be completed, signed and attached to your claim form)**

Are you presently employed?       Yes       No

If you are employed, please complete the following:

Employer's Name \_\_\_\_\_ Phone: \_\_\_\_\_

If you are now covered or were previously covered by your employer's health plan, please complete the following:

Name of insurance company: \_\_\_\_\_

Covered for medical insurance:     Self Only     Self & Dependents     None

Covered for dental insurance:     Self Only     Self & Dependents     None

Covered for vision insurance:     Self Only     Self & Dependents     None

Effective date of coverage: \_\_\_\_\_

If coverage has terminated, give date of termination: \_\_\_\_\_

If you are not covered by your employer's health plan at this time, please check one of the following boxes:

- I have not worked long enough to be covered.
- I do not work enough hours to be eligible.
- My employer does not offer health insurance to any employees.
- I elected not to be covered by my employer's health insurance.
- I was turned down for coverage by my employer's health insurance.

I represent that the answers given above are true and authorize Donley & Company, Inc. to obtain whatever additional information they may need from my employer or the insurer of my employer's health care plan to enable them to process my claim for benefits. A photocopy of this authorization shall be as valid as the original

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_