# *Cancellation of Duplicate Coverage*

CIGNA HealthCare

Please complete this form if you are no longer covered by two health benefits plans - for example, a spouse or former spouse's plan in addition to your own plan. By informing us that you're now only covered by one plan, you're helping us to coordinate your maximum allowable health benefits and make sure you receive prompt, fair and accurate processing of your claims. It's also required by law that you disclose the information we've requested.

**Please return this completed questionnaire form to the CIGNA HealthCare Claims Center listed on your CIGNA HealthCare ID card.** If you have any questions or need assistance in completing this form, simply call the Claims Center and a representative will be happy to help you.

***Please fill out form completely.*** **Please note: This form cannot be submitted online.** After filling in all of the fields, please print this form by clicking the button at the end of this form or by using your web browser's print function and mail it to the CIGNA HealthCare claims center listed on the back of your CIGNA HealthCare ID Card.

EMPLOYEE ENROLLED IN A CIGNA HEALTHCARE PLAN:

EMPLOYEE ADDRESS: *(Street)* *(Apt. #)* *(City)* *(State)* *(Zip Code)*

RELATIONSHIP: ☐ Self ☐ Spouse

CIGNA HEALTHCARE GROUP NUMBER:

CIGNA HEALTHCARE MEMBER ID NUMBER:

SPOUSE'S NAME:

SPOUSE'S DATE OF BIRTH:

SPOUSE'S SOCIAL SECURITY NUMBER:

IS YOUR SPOUSE EMPLOYED? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE THE EMPLOYER'S NAME AND ADDRESS:

*Employer Name:*

*Address:*

DOES YOUR SPOUSE PARTICIPATE IN A HEALTH BENEFITS PLAN OFFERED BY THIS EMPLOYER? ☐ Yes ☐ No

IF YES, WHAT'S THE HEALTH CARE CARRIER'S NAME, ADDRESS AND POLICY NUMBER?

*Carrier:* *Policy #:*

*Address:*

IS THIS GROUP COVERAGE? ☐ Yes ☐ No

WHEN DID YOUR SPOUSE'S COVERAGE BECOME EFFECTIVE?

WHEN DOES THIS COVERAGE PERIOD EXPIRE?

DOES YOUR SPOUSE'S COVERAGE EXTEND TO DEPENDENT CHILDREN? ☐ Yes ☐ No

IS YOUR SPOUSE RETIRED? ☐ Yes ☐ No

IF YES, WHAT IS THE DATE OF YOUR SPOUSE'S RETIREMENT?

ARE YOU COVERED BY MEDICARE? ☐ Yes ☐ No

IF YES, YOUR MEDICARE EFFECTIVE DATE:

IS YOUR SPOUSE COVERED BY MEDICARE? ☐ Yes ☐ No

IF YES, YOUR SPOUSE'S MEDICARE EFFECTIVE DATE:

WHO IS COVERED UNDER MEDICARE PART A? ☐ Self ☐ Spouse

WHO IS COVERED UNDER MEDICARE PART B? ☐ Self ☐ Spouse

ARE YOU OR YOUR SPOUSE COVERED UNDER MEDICARE BECAUSE OF KIDNEY FAILURE? ☐ Yes: ☐ Self ☐ Spouse ☐ No

WHEN DID KIDNEY DIALYSIS BEGIN?

SIGNATURE:

DATE SIGNED:

***Thank you for your cooperation in providing this information***



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Clear Fields Print Form