

OTHER INSURANCE INFORMATION UPDATE FORM

If you are not making changes to your medical plan, but have other insurance that is primary to your City of Memphis Plan, please complete and return this form. This will allow us to update our files with the most accurate information and enable us to process coordination of benefits correctly.

Participant Name: _____ Participant Social Security #: _____

Active/Retired/Survivor: _____ If Retired, Date of Retirement: _____

Other Insurance Information:

Name of Other Insurance Company: _____

Name of Insured: _____

Relationship of Insured to City Participant: _____ Group #: _____

Other Insurance Identification #: _____ Other Insurance Effective Date: _____

All Persons covered under this plan:

Medicare Coverage Information:

Employee/Retiree/Survivor Name: _____

Medicare Claim Number: _____

Medicare A: Yes No Effective Date: _____ Medicare B: Yes No Effective Date: _____

Medicare D: Yes No Effective Date: _____

Name of Spouse: _____

Medicare Claim Number: _____

Medicare A: Yes No Effective Date: _____ Medicare B: Yes No Effective Date: _____

Medicare D: Yes No Effective Date: _____

Return completed form to:

**Health, Wellness & Benefits Office
2714 Union Avenue Ext. 5th Floor Room 100
Memphis, Tennessee 38112**