Shawnee Mission School District

Coordination of Coverage

1. On the day the coverage begins, will you or any of your dependents applying for this coverage be covered by other health or dental insurance or Medicare, including continuation of coverage? □ YES □ NO If yes, answer all questions below. Attach sheet if more than one additional policy will be in force.		
COVERAGE TYPE □ Medical Insurance □ Dental Insurance	INSURANCE COMPANY NAME (AREA CODE) PHONE NO	Policy Number

NAME OF INSURED	INSURED'S EMPLOYER NAME	Effective Date	Termination Date

Family Members Covered

1. 2. 3.

2. Are any of your dependent children subject to a divorce decree or court order? □ YES □ NO

If yes, whose coverage is primary? □ Yours □ The Other Parent's

3. If you or your dependent(s) have Medicare, include a copy of your Medicare card(s) with this Application.

Do you or your dependent(s) have Medicare? □ YES □ NO If yes, are you actively working? □ YES □ NO

Are you retired? □ YES □ NO If yes, please provide date of retirement:

4. Are you or any of your dependent(s) covered under COBRA or State Continuation? □ YES □ NO

If yes, please provide the effective date and future termination date of coverage:

Effective Date: Future Termination Date:

Employee's Signature: _____

Printed Name: _____

Date: _____