

This Plan Covers: Medical Only Dental Only Medical and Dental

Plan #2 (if applicable)

Company _____

Plan Name _____

Address _____

City/State/Zip _____

Phone Number _____ Effective date of Coverage _____

Group Number _____ Policy Number _____

This plan is issued to (name) _____

Social Security or ID Number _____ Date of birth _____

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Section 3:

List the individual(s) on your Banner plan(s) who are covered by the other plan(s) mentioned above. Please indicate which plan(s) cover each person.

<u>Name</u>	<u>Relationship to Me</u>	<u>In Plan #1 and/or #2</u>	<u>Is Coverage Court Ordered(Y/N)</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Section 4

The information contained in this form is current as of today. I understand that if there are any changes in this information I need to notify Banner Plan Administration at (480) 684-7070, in the Phoenix metropolitan area or (800) 827-2464 all others within 31 days of the change.

Employee Signature: _____ Date: _____