Important Information Enclosed
Please Read Carefully

The UniCare State Indemnity Plan has a Coordination of Benefits (COB) provision. This provision applies if a UniCare State Indemnity Plan member with Medicare has other health plan coverage. COB means that we work with the other health plan to determine which health plan has primary responsibility for providing coverage. This provision lets the member utilize the coverage available in both plans.

Who must complete this form?

If you or a family member covered under both the UniCare State Indemnity Plan and Medicare is also enrolled in another health plan (other than MassHealth, AARP or TriCare), you must complete the Other Health Insurance form on the back of this notice and return it in the attached pre-addressed envelope within 30 days of receiving this notice. Please also include a copy of your ID card for the other health insurance plan, if available.

If you do not have other health plan coverage besides the UniCare State Indemnity Plan and Medicare, please disregard this notice. *Please note:* It is not necessary to inform us about coverage under Medicare, MassHealth, AARP, TriCare or any dental, vision or life insurance plans.

Questions?

If you have any questions or need additional information, please call Member Services at 1-800-442-9300 (TTY: 711). You can also e-mail us at contact.us@anthem.com

UNICARE STATE INDEMNITY PLAN/MEDICARE EXTENSION

Other Health Insurance Form

Employee / Retiree Information					
Last Name:	First Name:	MI:	Address:	Telephone: ( )	
Member ID Number:			City:	State:	Zip Code:

Other Health Coverage					
Please fill in the information below about any other health care coverage you or other family members have. **Do NOT include MassHealth, AARP, TriCare or dental, vision or life insurance plans.**					
Health Plan Name:			Plan Address:	Plan Telephone: ( )	
ID Number:	Group Number:	Effective Date:	City:	State:	Zip Code:
Name of Policyholder:			Are all family members covered under this plan? ☐ Yes ☐ No If no, who is covered:		
Policyholder's Relationship to UniCare State Indemnity Plan Enrollee / Retiree: ☐ Self ☐ Spouse ☐ Dependent ☐ Other ______					
Health Plan Name:			Plan Address:	Plan Telephone: ( )	
ID Number:	Group Number:	Effective Date:	City:	State:	Zip Code:
Name of Policyholder:			Are all family members covered under this plan? ☐ Yes ☐ No If no, who is covered:		
Policyholder's Relationship to UniCare State Indemnity Plan Enrollee / Retiree: ☐ Self ☐ Spouse ☐ Dependent ☐ Other ______					

I hereby acknowledge that the information I have provided on this form is correct and complete to the best of my knowledge.		**Did You Remember To:**
Signature:	Date:	▪ fill out all the blanks on the form? ▪ sign the form? ▪ enclose the form in the business reply envelope? ▪ enclose a copy of your ID card for the other health insurance plan?