Effective July 1, 2023

Lucent Health

STAYWELL
MENDOCINO COUNTY SCHOOL DISTRICTS HEALTH PLAN

Employee Name:_____ Member ID _____

Group Number: LHC00811 Pending Claims? ☐ Yes ☐ No

Do you or your family have other medical coverage? ☐ Yes, complete the below information ☐ No check this box and sign only

Do YOU have ANY other coverage? Yes☐ No ☐ If you have Dual Enrollment through Staywell, you MUST enter the information below.

Name of Other Insurance Company: _____

Address of Other Insurance Company _____

Policy Holder's Name: _____ Date of Birth: _____

Type of Policy: ☐ Employer Plan ☐ Individual

Effective Date: _____ Termination Date: _____

Does your Spouse have coverage available through another Benefit Plan? ☐ **Yes** ☐ **No**

Spouse Name:_____ Spouse Date of Birth:_____

Name of Other Insurance Company: _____

Address of Other Insurance Company _____

Policy Holder's Name: _____ Date of Birth: _____

Type of Policy: ☐ Employer Plan ☐ Individual Other Insurance Identification Number:_____

Effective Date: _____ Termination Date:_____

Do your Children have coverage available through another Benefit Plan? ☐ **Yes** ☐ **No**

Dependent Name:_____ Dependent Date of Birth:_____

Name of Other Insurance Company: _____

Address of Other Insurance Company _____

Policy Holder's Name: _____ Date of Birth: _____

Type of Policy: ☐ Employer Plan ☐ Individual Other Insurance Identification Number:_____

Effective Date: _____ Termination Date:_____

Dependent Name:_____ Dependent Date of Birth:_____

Name of Other Insurance Company: _____

Address of Other Insurance Company _____

Policy Holder's Name: _____ Date of Birth: _____

Type of Policy: ☐ Employer Plan ☐ Individual Other Insurance Identification Number:_____

Effective Date: _____ Termination Date:_____

_____ _____

Member Signature Date

Lucent Health

STAYWELL
MENDOCINO COUNTY SCHOOL DISTRICTS HEALTH PLAN

Dependent Name:______________________ Dependent Date of Birth:____________________

Name of Other Insurance Company: ____

Address of Other Insurance Company ____

Policy Holder's Name: ____________________ Date of Birth: ____________________

Type of Policy: ☐ Employer Plan ☐ Individual Other Insurance Identification Number:____________________

Effective Date: ____________________ Termination Date:____________________

Dependent Name:______________________ Dependent Date of Birth:____________________

Name of Other Insurance Company: ____

Address of Other Insurance Company ____

Policy Holder's Name: ____________________ Date of Birth: ____________________

Type of Policy: ☐ Employer Plan ☐ Individual Other Insurance Identification Number:____________________

Effective Date: ____________________ Termination Date:____________________

Dependent Name:______________________ Dependent Date of Birth:____________________

Name of Other Insurance Company: ____

Address of Other Insurance Company ____

Policy Holder's Name: ____________________ Date of Birth: ____________________

Type of Policy: ☐ Employer Plan ☐ Individual Other Insurance Identification Number:____________________

Effective Date: ____________________ Termination Date:____________________

Dependent Name:______________________ Dependent Date of Birth:____________________

Name of Other Insurance Company: ____

Address of Other Insurance Company ____

Policy Holder's Name: ____________________ Date of Birth: ____________________

Type of Policy: ☐ Employer Plan ☐ Individual Other Insurance Identification Number:____________________

Effective Date: ____________________ Termination Date:____________________

If you need additional room, please attach another sheet

______________________________ ____________________

Member Signature Date