Additional Information Form – EMPLOYEE PLANS, LLC

Subsidiary of Old National Insurance

Employee's Name (Last, First, MI)	ID #	Phone # ( )	Employer/Group Name & Number ASCOT 1251

1. Does your spouse have OTHER medical, dental, or vision coverage, including Medicare and/or Medicaid? ☐ Yes ☐ No (If yes, complete number 7)
2. Does your dependent child(ren) have OTHER medical, dental, or vision coverage, including Medicare and/or Medicaid? ☐ Yes ☐ No (If yes, complete number 8)
3. Are you actively employed? ☐ Yes ☐ No Retired? ☐ Yes ☐ No If retired, retirement date___________
4. Is your spouse employed? ☐ Yes ☐ No Retired? ☐ Yes ☐ No If retired, retirement date___________

If your plan has a special dependent eligibility provision (see Eligibility, Effective Date, and Termination section of the SPD), complete questions 5-6 below

5. Is your spouse eligible for health insurance coverage through their employer? ☐ Yes ☐ No
6. If your plan includes a special dependent eligibility provision (see Eligibility, Effective Date, and Termination section of the SPD), your spouse and/or dependents will need to comply with the provisions outlined in the SPD. Initial here ________
7. **Spouse's Insurance Company**:

Company Name	Name of Spouse	Date of Birth	Single Coverage ☐ Family Coverage ☐
Policy/Group Number	Individual ☐ Group ☐	Spouse's ID# (Social Security #, Member #, etc.)	
Insurance Co. Telephone # ( )	This Coverage is For: ☐ Medical ☐ Dental ☐ Vision ☐ Ortho ☐ Drug Card ☐ Medicare ☐ Medicaid	Effective Date:	Term Date:

8. Employee's dependent children that are currently covered under Employee Plans, LLC Medical Insurance Plan:

Name First	Last	Natural Parent's Name	DOB	Custodial Parent's Name	DOB	Step Parent's Name	DOB	Other Insurance Company Name: (Must supply court document if applicable)

If there is other insurance different than listed above, please send copy of front and back of insurance card.

9. If any of the dependents are children of divorced parents, please attach a copy of the most recent court document.

I CERTIFY ABOVE IS COMPLETE AND CORRECT. I AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PROVIDER TO RELEASE INFORMATION WHICH MAY BE NECESSARY TO DETERMINE BENEFITS PAYABLE UNDER THE PLAN, A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

(This release of information expires one year from the received date.)

Signature	Date	Spouse's Signature	Date

Return To: Employee Plans, LLC
P.O. Box 2362
Fort Wayne, IN 46801

Phone: 260-625-7470
Fax: 260-625-7530
www.oldnationalins.com