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Dear Member,

In an effort to maintain current and accurate information on our members and process your claims without delay, we ask that you please complete this form to ensure our files are up to date. Please indicate if you or your dependents have other insurance coverage below as well as provide the other insurance information if applicable. The form can be mailed to CDS Group Health P.O. Box 50190 Sparks, NV 89435; faxed to 775-352-7266; emailed to PHP-CDSHelpDesk@uhsinc.com; or you can call Customer Service at (775) 352-6900 or (800) 455-4236 toll free and we can take your information over the phone.

Subscriber Name: [] Subscriber ID number: []

Are you or your dependents covered under any other Health Plan? Yes No

If yes, please answer the following: Medical Dental Vision

Other Insurance Name: []

Other Insurance Phone Number: [] Effective Date: []

Policyholder Name: [] Policyholder Date of Birth: []

Please name the dependents covered under the other Insurance: []

Relationship to the Policyholder: [] If Parent: Natural Step

If divorced or separated, who has custody of the children?

Mother's name: [] Date of Birth: []

Father's name: [] Date of Birth: []

Is there a divorce decree/court order that outlines insurance responsibilities? Yes No

If yes, please attach a copy of this portion of the decree (unless previously submitted)

If we require additional information, please provide a contact number and best time to call: []

Are you or any other family member eligible for Medicare? Yes No

If yes, who? [] Effective Date for Medicare A: []

Medicare Number: [] Effective Date for Medicare B: []