GROUP HEALTH CDS
Customized • Dedicated • Service

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 775-770-9014; 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: _____