Luminare Health
PO Box 2920
Clinton, IA 52733-2920

luminare health℠
Experience. Solutions. Results.

AUHSD Employee Name: _____

AUHSD Employee Date of Birth: _____

Is your **spouse** or **any other eligible family member** covered by any other group insurance plan or government plan? ☐ Yes ☐ No

***Examples:** on employer sponsored plan, an association or trade group, Medicare, Medicaid

Medical ☐ Yes ☐ No

Other Medical Coverage Details

Coverage Type: ☐ Active ☐ Retiree ☐ Cobra

Additional Policy Holder Name: _____

Additional Policy Holder Date of Birth: _____

Insurance Name: _____

Coverage Effective Date: _____

Phone Number of Insurance Company: _____

Please list ALL family members currently covered under the other group MEDICAL plan including the policyholder.

Name of person covered	*Relationship to the policyholder with other coverage*	*Birth Date*

Government Coverage Details

Medicaid ☐ Yes ☐ No

Champus/Tricare ☐ Yes ☐ No

Medicare Part A ☐ Yes ☐ No *Effective date of coverage?* _____

Medicare Part B ☐ Yes ☐ No *Effective date of coverage?* _____

Medicare Part D ☐ Yes ☐ No *Effective date of coverage?* _____

What is the reason for the Medicare Coverage ☐ Working aged (>65) ☐ End-Stage Renal Disease ☐ Under 65 totally Disabled

If you have Medicare coverage, please include a copy of your Medicare card when responding.

Dependent Child Details

Is the dependent a child of divorced or separated parents? ☐ Yes ☐ No

Is there a document, such as a divorce decree (QMSCO), that states who is responsible for the health care expense of the child? ☐ Yes ☐ No

If yes, please include a copy of the portion of the document stating who is responsible for the child's health care coverage when responding.

Please indicate who is the custodial parent? _____

Please indicate who maintains the primary residence of the child? _____