verdegard

Formerly Known as HMA

Other Insurance Form

EUTF Supplemental Medical & Prescription Drug Plan

Please list all the non-EUTF group health plans you and your covered dependents are enrolled in. Return this form to Verdegard Administrators, LLC at 1440 Kapiolani Blvd., Suite 1000, Honolulu, HI 96814.

Name of Covered Individual	**Type of Plan** (e.g., Medical, Drug)	**Name of Plan** (e.g., HMSA, Kaiser, Med-QUEST*, Medicare*, VA)	**Effective Date**

*If you have Medicare or Med-QUEST, you will need other non-EUTF group coverage to be eligible for this plan.

MEDICARE COVERAGE (Check all that apply)				
Name of Covered Individual	**Enrolled in Medicare Part A?**	**Enrolled in Medicare Part B?**	**Eligible due to a disability?**	**Eligible due to end stage renal disease (ESRD)?**

I understand that I must have coverage under a non-EUTF group health plan to be eligible for the EUTF Supplemental Medical & Prescription Drug Plan and hereby declare that the above information is true to the best of my knowledge and belief.

Employee Name (Please Print): _____ Date: _____

Employee Signature: _____