JOHNS HOPKINS HEALTH PLANS

Other Health Insurance (OHI) Form

Please mail completed form to:

Johns Hopkins Health Plans
Enrollment Department
7231 Parkway Dr., Suite 100
Hanover, MD 21076

Note: When completing this form, please fill in circles completely. Do not use check marks.

☐ **No Other Health Insurance**
If you/your family have had no other health insurance in the last 12 months, please fill in the circle to the left, sign your name below and return this form in the enclosed prepaid envelope as soon as possible.

☐ **Commercial Health Insurance**
Please fill in this circle and complete this form if:
A: You or your family members who are enrolled in Johns Hopkins US Family Health Plan **currently** have any other health insurance, OR
B: You had any other health insurance that terminated within the last 12 months.

☐ **Medicare Part B**
If you and/or your spouse have Medicare Part B, please fill in the circle to the left and list the name(s) of the insured below.

Name: _____ Medicare Number: _____

Name: _____ Medicare Number: _____

Policyholder: _____ Date of Birth: _____ Today's Date: _____

Email: _____ Signature(s): _____

Name (*List member and dependents if applicable*)	Relationship to Policy Holder	Date of Birth	Other Health Insurance Y N
	Self		☐ ☐
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Please provide the required information about your other health insurance below:

Other Health Insurance Policy #1 (Please print)			
Insurance Company Name			
Insurance Company Address/Phone			
Effective Date of Coverage			
Termination Date of Coverage (if no longer insured by this company)			
Insurance Policy ID Number			
Insurance Policy Group Number			
Subscriber's Name			
Dependents Covered by this Policy (if applicable)			
This policy includes (select one): (Please fill in circle)	☐ Prescription Drug Coverage	☐ No Prescription Drug Coverage	☐ Only Prescription Drug Coverage
Other Health Insurance Policy #2 (Please print)			
Insurance Company Name			
Insurance Company Address/Phone			
Effective Date of Coverage			
Termination Date of Coverage (if no longer insured by this company)			
Insurance Policy ID Number			
Insurance Policy Group Number			
Subscriber's Name			
Dependents Covered by this Policy (if applicable)			
This policy includes (select one): (Please fill in circle)	☐ Prescription Drug Coverage	☐ No Prescription Drug Coverage	☐ Only Prescription Drug Coverage

If you have additional health insurance policies and need another form, you can download and print one at **www.hopkinsusfhp.org/OHI**, *or simply log in to your member portal to access and complete the web form. You may also request one by calling Customer Service at 800-808-7347.*

The statements made above are true and correct to the best of my knowledge. I understand that Federal Laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from uniformed services legal offices, public libraries and many beneficiary counseling and assistance coordinators.