BOON-CHAPMAN

P.O. Box 9201 / Austin, TX 78766 / (800) 252-9653 / Fax: (512) 233-7707
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2023 ANNUAL ADDITIONAL INSURANCE FORM

(This form must be completed and returned by all employees with enrolled dependents.)

Dear Texas Annual Conference (TAC) Group Health Plan Participant,

In accordance with the provisions of the TAC Group Health Plan, ***all employees with enrolled dependents must complete an annual form notifying Boon-Chapman of any other medical insurance plan that you or your dependents may have in place.*** Once this form is received, Boon-Chapman will determine which plan should pay primary for any medical claims received. ***If this form is not received by January 1 each year, Boon-Chapman will only pay claims for any dependents covered under the medical plan UP TO $1,000 per dependent. Once this amount is reached for an enrolled dependent, claims for that dependent will be rejected until this form is received, completed in full, at which time the claim(s) will be reprocessed according to plan benefits.***

Please complete the following information and return this form to Boon-Chapman at the fax number, e-mail, or physical address listed above. Failure to complete and return this form may result in future claim denial. If you have any questions, please contact our Customer Service Team @ (800) 252-9653.

1. Employer's Name: **Texas Annual Conference of the United Methodist Church**

2. Employee's Name: ____

3. Employee's Social Security Number or Employee I.D.____________________ Group Number: 002928

4. Are **you** covered by any other medical insurance? Yes _____ No _____

5. If you answered "Yes" to question 4, please complete the following:
   a) Other Medical Insurance Carrier Name: ______________________________
   b) Other Medical Insurance Carrier Phone #: ______________________________
   c) Other Medical Insurance Effective Date: ______________________________

6. Are any of your **enrolled** family members covered by other medical insurance? Yes_____ No_____

7. If you answered "No" to question 6, please sign and date and return this form.

8. If you answered "Yes" to question 6, please complete the following:
   a) Other Medical Insurance Policy Holder's Name: ______________________________
   b) Other Medical Insurance Policy Holder's ID: ______________________________
   c) Other Medical Insurance Policy Holder's Date of Birth: ______________________________
   d) Other Medical Insurance Policy Holder's Effective Date of Coverage: ____________________
   e) Other Medical Insurance Carrier's Name: ______________________________
   f) Other Medical Insurance Carrier's Phone #: ______________________________
   g) Please complete the following for all dependents:

	Dependent Name*	Covered by Other Insurance listed above?	
a		Yes	No
b		Yes	No
c		Yes	No
d		Yes	No
e		Yes	No

*Please list any additional dependents on the back of this form.

I hereby certify that the statements and answers are complete and true to the best of my knowledge.

______________________________________ ____________________
Signature of Participant Date