TRUSTMARK HEALTH BENEFITS
PO Box 2920
Clinton, IA 52733-2920

Trustmark
benefits beyond benefits

IMPORTANT INFORMATION FOR AUHSD EMPLOYEES WITH SPOUSE AND DEPENDENT COVERAGE

In order to **avoid a delay in claim payment**, if you have enrolled a spouse and/or dependents in the AUHSD health benefit plan we need you to contact Trustmark Health Benefits to confirm whether your SPOUSE and/or DEPENDENTS have any other medical insurance.

To make this process easier, there are four ways you can respond.

1. Contact Trustmark Health Benefits Customer Service Line at: 866-280-4120

2. Complete this form and fax to: 913-387-5952

3. Complete this form and mail to:
   Trustmark Health Benefits
   P.O. Box 2920
   Clinton, IA 52733 - 2920

4. Send a portal message by completing the following the steps
   - Register and sign into your www.mytrustmarkbenefits.com portal account
   - Click “Messages” and then “New Message” from the dropdown
   - Select “General Inquiry “
   - Write out the body of your message with a subject line – *Example: “Coordination of Benefits”*
   - Answer the questions in the body of the message
   - If you may also include a copy of the letter as an attachment, if you have it saved it to your device. Simply select “Browse” and find the file you would like to attach, double click, and hit “Send”

**Please note: If you have employee only coverage, you do not need to respond.*

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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:** an 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 expenses 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? ______________________