SUBSCRIBER THIRD PARTY LIABILITY FORM
FOR INSURE OKLAHOMA/O-EPIC

Instructions

Please PRINT or TYPE. Use only BLUE or BLACK ink to complete this form. Failure to provide the information requested may result in your Insure Oklahoma/O-EPIC enrollment being terminated. The TPL form must be signed and dated by the applicant.

For additional assistance or information, call our helpline at **1-888-365-3742** or visit our website at **www.insureoklahoma.org**. For the hearing impaired, call **(405) 416-6848** (TDD/TTY).

Mail to: **Oklahoma Health Care Authority, Attention: TPL, 2401 N.W. 23rd Street, Suite 1-A, Oklahoma City, OK 73107.**

To maintain accurate records, Insure Oklahoma/O-EPIC requires the following information:

(Make copies of this form as necessary for each health coverage plan)

Applicant and Dependent Information:

Besides Insure Oklahoma/O-EPIC, are you or your dependents enrolled in any other group insurance or benefit plan including Medicare? Yes ☐ *(Please complete the information below)* No ☐ *(Please sign and mail to the above address)*

Policy Holder's Name: Last: ________________________ First: ____________________ MI: ___ SSN: _____-____-______

Policy Holder's Health Insurance Company: ____________________________________ Phone: (_____) _________________

Address____

Policy #: _______________________________ Group #: _______________________________

Effective Date: *(mm/dd/yyyy)*: _____/_____/__________ Termination Date: *(mm/dd/yyyy)*: _____/_____/__________

Coverage: Single ☐ Family ☐

Does the plan provide (*check all that apply*): Medical ☐ Pharmacy ☐ Dental ☐ Vision ☐

Other ☐____

Please list all persons covered by the policy stated above

Applicant's Name: Last: ___________________________ First: ____________________ MI: ___ SSN: _____-____-______

Date of Birth *(mm/dd/yyyy)*: _____/_____/__________

Dependent's Name: Last: __________________________ First: ____________________ MI: ___ SSN: _____-____-______

Date of Birth *(mm/dd/yyyy)*: _____/_____/__________

Dependent's Name: Last: __________________________ First: ____________________ MI: ___ SSN: _____-____-______

Date of Birth *(mm/dd/yyyy)*: _____/_____/__________

Dependent's Name: Last: __________________________ First: ____________________ MI: ___ SSN: _____-____-______

Date of Birth *(mm/dd/yyyy)*: _____/_____/__________

Dependent's Name: Last: __________________________ First: ____________________ MI: ___ SSN: _____-____-______

Date of Birth *(mm/dd/yyyy)*: _____/_____/__________

Dependent's Name: Last: __________________________ First: ____________________ MI: ___ SSN: _____-____-______

Date of Birth *(mm/dd/yyyy)*: _____/_____/__________

Dependent's Name: Last: __________________________ First: ____________________ MI: ___ SSN: _____-____-______

Date of Birth *(mm/dd/yyyy)*: _____/_____/__________

The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay the State of Oklahoma for any payments or claims incurred which were paid due to my fraud or error. (28 USC 1746)

Signature: ____ **Date:** _________________________