



Insure Oklahoma/O-EPIC

Important:

Please complete, sign, and return the enclosed State of Oklahoma Subscriber Third Party Liability form using the prepaid envelope marked “TPL Cost Avoidance Unit.”

If you have any questions about this form or the Insure Oklahoma/O-EPIC program, please feel free to call our Insure Oklahoma/O-EPIC helpline at 1-888-365-3742.

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, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, OK 73105.**

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:** _____