



OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

Name: _____

ID Number: _____

Address: _____

Date: _____

1. Do you or any dependents have any other group health, dental, or Medicare coverage? No Yes
IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM TO US OR CALL CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD.

Your Signature _____ Date _____

2. Please list the family members covered by the other policy and the type of coverage you have.
- | | | | | | |
|-------|----------------------------------|-----------------------------------|-------------------------------|---------------------------------|-----------------------------------|
| _____ | <input type="checkbox"/> Medical | <input type="checkbox"/> Hospital | <input type="checkbox"/> Drug | <input type="checkbox"/> Dental | <input type="checkbox"/> Medicare |
| _____ | <input type="checkbox"/> Medical | <input type="checkbox"/> Hospital | <input type="checkbox"/> Drug | <input type="checkbox"/> Dental | <input type="checkbox"/> Medicare |
| _____ | <input type="checkbox"/> Medical | <input type="checkbox"/> Hospital | <input type="checkbox"/> Drug | <input type="checkbox"/> Dental | <input type="checkbox"/> Medicare |
| _____ | <input type="checkbox"/> Medical | <input type="checkbox"/> Hospital | <input type="checkbox"/> Drug | <input type="checkbox"/> Dental | <input type="checkbox"/> Medicare |

For additional family members, attach sheet with information.
* **If you checked Medicare, answer number 7.**

3. Name of other policyholder. _____

Other policyholder's date of birth _____ Relationship to you _____

4. Employer name if coverage is provided through an employer. _____

5. Name of other insurance company and effective date of policy. _____ Effective Date _____

If policy is now terminated, please give termination date. _____ ID # _____

6. If there is a divorce or separation, please list who is responsible for the healthcare expenses. _____

If there is a copy of a divorce decree, please forward a copy to us.

If there is not a court decree, who has custody of the children? _____

******* SECTION PERTAINS TO MEDICARE COVERAGE ONLY *******

7. Is the policyholder actively working? Yes No Beginning date of employment _____
Last day of active employment _____

8. Are you or any family members covered by Medicare? No Yes If No, please sign and date below. If Yes, please complete the information below.

• Name _____ Date of Birth _____

Medicare Number _____ Part A Effective Date _____

Part B Effective Date _____

Reason for Medicare (check one) Age
 Disability
 ESRD Date of first dialysis _____

• Name _____ Date of Birth _____

Medicare Number _____ Part A Effective Date _____

Part B Effective Date _____

Reason for Medicare (check one) Age
 Disability
 ESRD Date of first dialysis _____

Your Signature _____ Date _____