Today's Date: _____(mm/dd/yyyy)_____

Subscriber Name: _____

ID Number: _____

Group Number: _____

OTHER COVERAGE QUESTIONNAIRE

Your contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact the policyholder's plan immediately.

SECTION A - OTHER INSURANCE

Are you or any other member of this policy covered by any another medical, dental or vision insurance policy, including any other BlueCross, BlueShield or Medicare policy?

☐ **No** - If No, please complete Section D, sign, indicating "No other insurance."

☐ **Yes** - If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

If you have more than one coverage, please submit a separate form.

Mark all that apply: ☐ Other Health Insurance ☐ Other Dental Insurance ☐ Other Vision Insurance ☐ Other Pharmacy Insurance

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name			
Address	City	State State	ZIP Code
Phone Number (xxx) xxx-xxxx	Dependent(s) listed on the other insurance		
Other Insurance Policyholder's Name	Policyholder's Date of Birth (mm/dd/yyyy)	ID Number	

Effective Date of Other Insurance _____(mm/dd/yyyy)_____

If cancelled, cancellation date _____(mm/dd/yyyy)_____

Is the policyholder actively working for the group? ☐ Yes ☐ No	Is the policyholder inactive? ☐ Yes ☐ No
Retired? ☐ Yes ☐ No Retirement Date (mm/dd/yyyy)	On COBRA? ☐ Yes ☐ No Effective Date (mm/dd/yyyy)

Policyholder's Employer			
Address	City	State State	ZIP Code
Phone Number (xxx) xxx-xxxx			

SECTION B - MEDICARE INFORMATION

Does the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No (if this does not apply, skip to Section C)

Name of person(s) with Medicare	Medicare Number, including alpha character(s)

Effective Date of Medicare Part A (mm/dd/yyyy)	Effective date of Medicare Part B (mm/dd/yyyy)

Medicare Entitlement: ☐ Age Disability* ☐ End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

First Date of Disability (mm/dd/yyyy)	First Date of Dialysis for ESRD (mm/dd/yyyy)

Was ESRD started in a facility? ☐ Yes ☐ No | Was ESRD started as Self Dialysis or Home Dialysis? ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No If yes, please provide the date of the transplant (mm/dd/yyyy)

SECTION C - COURT ORDER INFORMATION

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? ☐ Yes ☐ No
(if this does not apply, skip to Section D)

If Yes, documentation of the court order is required if one exists. Please fax to 1 (888) 661-2850.

List the name(s) of the dependent(s) that this applies to

What is the relationship to the child(ren)?	Who has custody of the child(ren) more than 50% of the time?

SECTION D - NAME(S) OF DEPENDENT(S) ON POLICY

Name	Relationship	Sex	Social Security Number (optional)
Name	Relationship	Sex	Social Security Number (optional)
Name	Relationship	Sex	Social Security Number (optional)

Policyholder Signature	Date (mm/dd/yyyy)