

### 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.

\_\_\_\_\_ ID Number: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ 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 OR CALL US AT OUR COB HOTLINE (1-800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.**

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 |
| _____ | <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 a separate sheet with the information.

\* If you checked Medicare, answer question #7.

3. Name of Other Policyholder: \_\_\_\_\_

Other Policyholder's Date of Birth: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

4. Employer's 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 health care 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. Are you actively working?  Yes  No Beginning date of employment: \_\_\_\_\_ Last day of active employment: \_\_\_\_\_  
 8. Is your spouse actively working?  Yes  No Beginning date of employment: \_\_\_\_\_ Last day of active employment: \_\_\_\_\_

9. 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: \_\_\_\_\_

Please mail this form to your plan at the address above. Include the name of your health plan. Or fax it to: 803-736-8341.