



BENEFIT MANAGEMENT

S E R V I C E S
Customer Service: 800.603.2299 • Fax: 225.297.2885

P. O. Box 98044
Baton Rouge, LA 70898-9044

OTHER COVERAGE QUESTIONNAIRE IMPORTANT DOCUMENT

PLEASE CHECK REASON FOR SUBMISSION:

- Annual COB update
 New enrollee
 Add other insurance
 Termination of other insurance

Group Policy Number _____ Group or Employer Name _____

Member ID Number _____ Member/Employee Name _____

Address _____ Phone Number _____

SECTION A – OTHER INSURANCE

Are you or any other dependent covered by another medical or dental insurance policy?

- No If No, please complete section D, sign, date and return this questionnaire to us, including “No other insurance.”
 Yes If yes, please complete all of the fields below that pertain to the member(s) that has the other coverage

Mark those that apply:
 Other Health Insurance
 Other Dental Insurance
 What type of policy is this?
 Group
 Individual Policy
 Student Policy
 Medicare Supplemental

Other Insurance Carrier's Name

Address

City	State	Zip	Phone Number
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NAME(S) OF DEPENDENTS ON POLICY

Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number
Name	Relationship	Date of Birth	Sex	Social Security Number

Other Insurance Member's Name

Member's Date of Birth

ID Number

Original Effective Date of Other Insurance

If Cancelled, Cancellation Date

Is the member:
 Actively working for the group
 Inactive
 Retired, retirement date: _____
 On COBRA, which began : _____

Member's Employer

Address

City	State	Zip	Phone Number
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SECTION B – MEDICARE INFORMATION If this does not apply, skip to Section CDoes the member and/or dependent(s) have Medicare? Yes No

Name of person(s) with Medicare

Medicare Number, including alpha character(s)

Effective date of Medicare Part A

Effective date of Medicare Part B

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

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

1st Date of Disability: _____1st Date of Dialysis for ESRD: _____Has a transplant been performed? Yes No If yes, please provide the date of the transplant. _____**SECTION C – COURT ORDER INFORMATION If this does not apply, skip to Section D**Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? Yes No

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

If yes, who is the person(s) listed to maintain health coverage?

What is the relation to the children?

Who has custody of the child(ren) more than 50% of the time?

*Documentation of the court order may be requested from your Health Plan Administrator.***SECTION D****I HEREBY CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE TRUE,
CORRECT AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

INSURED'S SIGNATURE

INSURED'S SOCIAL SECURITY NUMBER

X

DATE

SPOUSE'S NAME

INSURED'S DAYTIME TELEPHONE NUMBER

SPOUSE'S SOCIAL SECURITY NUMBER