



BENEFIT MANAGEMENT

S E R V I C E S

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

OTHER COVERAGE QUESTIONNAIRE IMPORTANT DOCUMENT

Please fill out this questionnaire and return it to us within ten (10) days. **Until this information is received, we cannot process any claims you submit.**

We appreciate your prompt response.



ARE YOU:	
<input type="checkbox"/> EMPLOYED	<input type="checkbox"/> RETIRED _____ DATE
<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
<input type="checkbox"/> SINGLE/WIDOWED	
<input type="checkbox"/> DIVORCED/LEGALLY SEPARATED	

____ FOLD

In addition to your employer group health plan coverage, are you, your spouse, or dependent children currently covered or have been covered within the last 63 days by Medicare or another group/individual health insurance plan?

- YES Please complete the remainder of this questionnaire.
- NO Please complete Section C, sign the questionnaire and return it to us.

CREDITABLE COVERAGE AND/OR OTHER COVERAGE QUESTIONNAIRE

Please fill out this questionnaire and return it within ten (10) days. **Until this information is received, we cannot process any claims you submit.**

This notice is to inform you of the pre-existing condition exclusion in your employer group health plan, and your rights to demonstrate prior creditable coverage.

Notice of Pre-existing Condition Limitation

Your employer group health plan will not cover any condition, including physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received, within a period of six (6) months prior to enrollment under the plan or commencement of any applicable waiting period to become enrolled under the plan.

This preexisting condition period will last for twelve (12) months, or eighteen (18) months for late enrollees, from the earlier enrollment under the plan or commencement of any applicable waiting period to become enrolled under the plan.

Credit For Prior Health Care Coverage

You, your spouse or dependents may be able to reduce any applicable preexisting condition period by showing proof of prior creditable health care coverage. This includes health care coverage through an employer, COBRA continuation coverage, Medicare, Medicaid, Military health plans, and individual policies. You should have received a Certificate of Creditable Coverage from your previous health care company or employer. This certificate will state that you had coverage and the periods of coverage. If you did not receive or lost your Certificate of Creditable Coverage, you can contact the former health care company or employer. If you need assistance in obtaining a Certificate of Health Care Coverage, please contact the plan administrator.

Only coverage that was maintained within the last 62 days (exclusive of any waiting periods) will be counted towards the preexisting condition exclusion period. You will not receive any credit for health insurance coverage you had prior to any 63-day break in coverage.

In addition to your employer group health plan, are you, your spouse, or dependent children currently covered or have been covered within the past 63 days by Medicare or another group/individual health insurance plan?

SECTION A

Please complete this section if you have other group/individual health insurance coverage or prior health insurance coverage sponsored by an employer. If you, your spouse or dependents have no health coverage or prior creditable coverage, please go to section B. If you have no Medicare coverage go to section C.

NAME OF POLICY HOLDER OF OTHER INSURANCE			SEX			
LAST		FIRST		M. I.		
				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
DATE OF BIRTH		SOCIAL SECURITY NUMBER			RELATIONSHIP TO YOU	
MONTH	DAY	YEAR				
					<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> OTHER _____	

