South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Federal Employee Customer Service
P.O. Box 100603
Columbia. SC 29260-9982

Visit our Web site at:
www.SouthCarolinaBlues.com

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: ______________________

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______________________ 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.

______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ 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? ______________

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* * * * * **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.

(10850) Rev. 10/00 *WE WILL NOT CONSIDER **CLAIMS FOR PAYMENT WITHOUT THIS INFORMATION.***