



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 sheet with information.

*** If you checked Medicare, answer number 7 on page 2.**

3. Name of other policyholder. _____

Other policyholder's date of birth: _____ Relationship to you: _____

4. Employer 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 healthcare 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 Begin date _____ Last day of active employment _____

8. 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

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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 or fax this form to the correct plan listed below.

- State Health Plan ("ZCS" Alpha Prefix) State Health Plan: AX-B10
ATTN: COB
P.O. Box 100605, Columbia, SC 29260-0605
FAX (803) 699-7675
- Federal Employee Plan/FEP ("R" Alpha Prefix) Federal Employee Customer Service
P.O. Box 100603
Columbia, SC 29260-9982
FAX (803) 736-8341
- Small Group and Individual ("ZCY" Alpha Prefix) Group and Individual: AF-225
ATTN: COB
P.O. Box 100246, Columbia, SC 29202-3246
FAX (803) 264-0172
- Preferred Blue® and all other BlueCross plans (Include name of health plan.) BlueCross BlueShield of South Carolina
P.O. Box 100300
Columbia, SC 29202
Check your member ID card for Service Center location:
Piedmont (Greenville) Service Center: FAX (803) 264-9128
Columbia Service Center: FAX (803) 264-6572

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