Other Insurance Questionnaire

This form must be completed to notify the Plan of Medicare or other health coverage for Coordination of Benefits (COB). ***If you or your dependents do not have other coverage, check the box on the back of this form, sign and return to us.*** If you or any member of your family has other health coverage that has not been previously submitted, or have a change in other health coverage information, please complete the form and mail to:

Claims Department, PO Box 2920, Milwaukee, WI 53201-2920

Please check reason for submission: ☐ **Document that no other coverage exists**

☐ **Add Other Coverage Information** ☐ **Change in Other Coverage** ☐ **Termination of Other Coverage**

Employer Name: ____________________ Employer Group #: ____________

Employee Name: ____________________ Member ID #: ____________

Employee Address: ____

____________________ Work Phone: ____________

Email Address: Home Phone:

SECTION A - MEDICARE COVERAGE **attach Medicare Entitlement Letter if applicable*

If you or your spouse have Medicare coverage, please complete the following:

Employee Coverage (yourself)

Social Security # ____________

Medicare ID# ____________

Date of Birth (MM/DD/YY)

Coverage type(s)

Hospital Part A: Effective Date ____________

Medical Part B: Effective Date ____________

☐ Active ☐ Retired (date)

Reason for Medicare:

☐ Over 65 ☐ Disabled

☐ ESRD (End Stage Renal Disease)

Medicare Entitlement Date: ____________

Spouse Coverage

Spouse Name ____________

Social Security # ____________

Medicare ID# ____________

Date of Birth (MM/DD/YY) ____________

Coverage type(s)

Hospital Part A: Effective Date ____________

Medical Part B: Effective Date ____________

☐ Active ☐ Retired (date)

Reason for Medicare:

☐ Over 65 ☐ Disabled ☐ ESRD

Medicare Entitlement Date: ____________

SECTION B - OTHER HEALTH INSURANCE

Please complete this section if you, your spouse or other dependents will have other health coverage in addition to your coverage through your employer plan. (Use additional paper if necessary.)

Type of Coverage: (Medical, Dental or Both)____________________

First Name	Last Name	Relationship	Coverage Eff Date	Reside in Same household
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Policyholder Name ____________________ Member ID# ____________

Date of Birth ____________ Address: ____________________

Insurance Carrier Name ____________________ Phone ____________

Insurance Carrier Address: ____________________

For dependent(s) listed above, are you responsible for providing Primary Health Coverage: ☐ Yes ☐ No

If you are not responsible, provide name of responsible party ____________________

NOTE: Please complete **SECTION C** for dependent children of divorced parents.

SECTION C - DEPENDENT CHILDREN OF DIVORCED PARENTS

Please complete this section for any dependent child(ren) listed in **SECTION B** when parents are divorced, or have some other legal reason for providing coverage. (Use additional paper if necessary.)

Name of child(ren) 1. ____________________ 2. ____________________ 3. ______________________
4. _____________________ 5. ________________________ 6.____________________________

Parents are: ☐ Divorced ☐ Other
If parents are divorced, parents have: ☐ Joint Custody
☐ One Parent with Custody
Parent with Custody: Name ____________________________ ☐ Remarried ☐ Not Remarried

Is there a legally binding agreement stating which parent has responsibility for the child's health care expenses?
☐ Yes ☐ No If Yes, which parent? Name ____

SECTION D - TERMINATION OF OTHER HEALTH INSURANCE

Please complete this section if the other health insurance or Medicare coverage has been replaced by another health

First Name	Last Name	Relationship	Coverage Term Date

Policyholder Name ______________________________

Insurance Carrier Name ______________________________

SECTION E - STATEMENT OF NO OTHER COVERAGE

☐ I hereby state that neither myself nor any of my eligible dependents covered under this Plan through my employer are currently covered by another medical, dental or vision plan.

SECTION F - SIGNATURE

I understand that the information provided on this form is true, complete and correctly recorded and will be used by BAS for coordination of benefits and adjudication of claims. My signature authorizes coordination of benefits under my health plan with other insurance plans that are subject to coordination of benefits and for recovery of funds from another party found to be responsible for claims. If the information provided on this form changes, I agree to notify BAS.

Employee Signature Employee Member ID# Date