

If there is not a court decree, who has custody of the children?

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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? ☐ 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 ☐ Medicare ☐ Drug ☐ Dental ☐ Medical ☐ Hospital ☐ Drug ☐ Dental ☐ Medicare ☐ Dental ☐ Medical ☐ Hospital ☐ Drug ☐ Medicare ☐ Hospital ☐ Drug ☐ Dental ☐ Medicare ☐ Medical ☐ Medical ☐ Hospital ☐ Drug ☐ Dental ☐ Medicare For additional family members, attach a separate sheet with the information. * If you checked Medicare, answer question #7 on page 2. 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 Effective Date: Policy: 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.

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7. Are you actively working?	□ Yes □ No Star	Last Day of Active t Date: Employment:
	amily members covered by Medicare? n and date below. If Yes, please complete	
	• Name:	Date of Birth:
	Medicare Number:	Part A Effective Date:
	Reason for Medicare (check one):	Part B Effective Date:
		☐ 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 or fa	ax this form to the correct plan:	
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: AX-F25 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