Other Group Coverage Questionnaire

Premera Blue Cross
PO Box 33932
Seattle, WA 98133-0932
1-800-562-1011

BlueCross BlueShield
Federal Employee Program

Important: Please return within ten days with claim forms, if any are attached.
Your claim(s) cannot be processed without this information.

Date _____

Subscriber ID Number: _____

Dear Mr./Ms. _____:

To reduce the cost of health care, your Federal Employee Program has a coordination of benefits provision. This means that if you or other family members have other group medical, dental or vision coverage, we must contact the other carrier(s) and share the cost of your claim(s).

Please answer the following questions. Sign (x) and return this form (with claim(s) if attached) within five days. Your cooperation is appreciated.

OTHER GROUP INSURANCE INFORMATION

Do you or any family members have any of the following:

1. Premera Blue Cross coverage (other than Federal Employee Program)? ☐ No ☐ Yes. If "Yes": (see #4)
2. If your other insurance has been terminated, please provide policy name and termination date. _____
3. Medicare coverage? ☐ No ☐ Yes. If "Yes":
   Medicare ID number _____

NAME OF FAMILY MEMBER WITH MEDICARE	Medicare A effective _____ Medicare B effective _____

4. Other medical, dental or vision coverage? ☐ No ☐ Yes. If "Yes", please complete the following section. If more than one policy, attach an additional sheet of paper.

Other Group Insurance Company:

INSURANCE COMPANY NAME	
ADDRESS (STREET)	
CITY / STATE / ZIP	Selec
TELEPHONE NUMBER ( )	
☐ Self ☐ Two Person ☐ Family	

NAME OF POLICY HOLDER	RELATIONSHIP TO FEP SUBSCRIBER
POLICY ID NO. (SOCIAL SECURITY NO., MEMBER NO., ETC.)	POLICY HOLDER'S DATE OF BIRTH
GROUP NO. (CERT. NO., UNION LOCAL, ETC.)	
THIS COVERAGE IS FOR: ☐ Medical ☐ Dental ☐ Vision	
NAME OF EMPLOYER PROVIDING YOUR GROUP COVERAGE	
ARE YOU RETIRED FROM THIS EMPLOYER? ☐ No ☐ Yes	EFFECTIVE DATE OF INSURANCE

5. If parents are divorced or legally separated, the following information is needed to determine which group coverage will process claims first for dependent children. (Please include additional dependent names on back of form.)

CHILD'S NAME FIRST	CHILD'S NAME LAST	NAME OF PERSON WITH CUSTODY	RELATIONSHIP TO CHILD LISTED	NAME OF PERSON WITH FINANCIAL RESPONSIBILITY FOR HEALTH COVERAGE ACCORDING TO DIVORCE DECREE	RELATIONSHIP TO CHILD LISTED	NAME OF OTHER GROUP COVERAGE PROVIDED*

* If this is different than the other group insurance company listed in question 4 above, please list all other coverage information on a separate sheet.

The above information is accurate and complete to the best of my knowledge.

SIGNATURE OF SUBSCRIBER OR SPOUSE
x

Thank you for your prompt response.

004965 (05-28-2019)