Visit our Web site at: www.tccba.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.

Name: ______________________________ ID Number: ______________________
Address: ______________________________
Address: ______________________________ 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 1-800-815-3314 AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEEED 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 on page 2.**

3. Name of Other Policyholder: ______________________________

Other Policyholder's Date of Birth: ______________ Relationship to You: ______________

4. Employer's Name, If Coverage 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? ______________________________

*** * * * * SECTION PERTAINS TO MEDICARE COVERAGE ONLY * * * * ***

7. Are you actively working? ☐ Yes ☐ No Start Date: ________________ Last Day of Active Employment: ________________

8. Are you or any family members covered by Medicare? ☐ Yes ☐ No

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 or fax this form to:

TCC Benefits Administrator
P.O. Box 63477
North Charleston, SC 29419
Phone: (800) 815-3314
Fax: (803) 264-0803
Email: service@tccba.com