



**OTHER HEALTH/DENTAL
COVERAGE QUESTIONNAIRE**

Visit our Web site at: www.tccba.com

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: _____
Address: _____
Address: _____

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 1-800-815-3314 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 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
Administrators
P.O. Box 22557
Charleston, SC 29413
Phone: (800) 815-3314
Fax: (803) 264-0803
Email: inquiries@tccba.com