PLANNED ADMINISTRATORS INC

Post Office Box 6927
Columbia, SC 29260

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 correctly process your claims.

Name: ______________________________________ ID Number: __________________________________

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 (866) 798-0803 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	☐ Dental	☐ Vision	☐ Medicare
____	☐ Medical	☐ Dental	☐ Vision	☐ Medicare
____	☐ Medical	☐ Dental	☐ Vision	☐ Medicare
____	☐ Medical	☐ Dental	☐ Vision	☐ Medicare
____	☐ Medical	☐ Dental	☐ Vision	☐ Medicare

   For additional family members, attach a separate sheet with the information.

   If you checked Medicare, answer questions #8 & #9 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 of Policy: ____
   Effective Date: ____________________________
   If policy is now terminated, please give termination date: ________________________ ID#: _____________________

6. The Other Insurance Company's Address: ____

7. 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? ____

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

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

9. 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: ______________________

Your Signature: ____ Date: ______________________________

Please sign, date, and return this form to:

Planned Administrators, Inc.
P.O. Box 6927
Columbia SC 29260
Attn: PAI LB Eligibility/In-House 3

OR Fax (803) 264-8739