TCC Benefits Administrator℠

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 22557
Charleston, SC 29413
Phone: (800) 815-3314
Fax: (803) 264-0803
Email: service@tccba.com