



**MULTIPLE COVERAGE INQUIRY**

In order to pay your claims quickly and accurately, we need complete information on other health care coverage that you or your dependents may have. **Please complete this form and return it as soon as possible.**

1. PLEASE ANSWER THIS QUESTION	
<p><b>Do you, or any family member, have any other health insurance coverage or has any such coverage existed during the last six months? Include coverage by our company, any other company, any other Blue Shield or Blue Cross coverage, any retirement plan or Medicare.</b></p> <p><b>YES</b> <input type="checkbox"/> If Yes, please complete sections 2, 3, and 4 (space has been provided on the back of this form for persons with more than one other health care plan).</p> <p><b>NO</b> <input type="checkbox"/> If No, please sign and date the bottom of this form (Section 4), list your telephone number, and return the form to us as soon as possible.</p>	

2. OTHER INSURANCE INFORMATION (More space provided on the back of this form)			
Name of Insurance Company			Insurance Company Telephone Number
Insurance Company Address (Street or PO Box, City, State, and Zip Code)			
Name of Policyholder	Date of Birth	Policyholder Identification Number	Policyholder Social Security Number
Employer	Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended: _____	
Type of Coverage	<input type="checkbox"/> Medical	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental
		<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Pharmacy
Type of Policy	<input type="checkbox"/> Group	<input type="checkbox"/> Individual	<input type="checkbox"/> Medicaid
		<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> Medicare Part B

Persons Covered by Other Insurance					
Name	Date of Birth	Relationship to Policyholder	Name	Date of Birth	Relationship to Policyholder

3. If your dependent child(ren) are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:		
Name of Parent With Custody (if parents have dual custody, indicate)	If divorced, did the court establish financial responsibility for the children's health care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, specify the name of the person with financial responsibility	Date of Divorce	<b>INCLUDE A COPY OF THE CHILD MAINTENANCE AGREEMENT FROM THE DIVORCE DECREE.</b>
Address of Person With Financial Responsibility (Street or PO Box, City, State and Zip Code)		

4. SUBSCRIBER'S SIGNATURE			
Subscriber's Signature	Date	Work Telephone	Home Telephone

OTHER INSURANCE INFORMATION					
Name of Insurance Company				Insurance Company Telephone Number	
Insurance Company Address (Street or PO Box , City, State, and Zip Code)					
Name of Policyholder		Date of Birth	Policyholder Identification Number	Policyholder Social Security Number	
Employer		Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended: _____		
Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Chiropractic <input type="checkbox"/> Pharmacy					
Type of Policy <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B					
Persons Covered by Other Insurance					
Name		Date of Birth	Relationship to Policyholder	Name	

OTHER INSURANCE INFORMATION					
Name of Insurance Company				Insurance Company Telephone Number	
Insurance Company Address (Street or PO Box , City, State, and Zip Code)					
Name of Policyholder		Date of Birth	Policyholder Identification Number	Policyholder Social Security Number	
Employer		Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended: _____		
Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Chiropractic <input type="checkbox"/> Pharmacy					
Type of Policy <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B					
Persons Covered by Other Insurance					
Name		Date of Birth	Relationship to Policyholder	Name	

OTHER INSURANCE INFORMATION					
Name of Insurance Company				Insurance Company Telephone Number	
Insurance Company Address (Street or PO Box , City, State, and Zip Code)					
Name of Policyholder		Date of Birth	Policyholder Identification Number	Policyholder Social Security Number	
Employer		Employer Group ID Number	Date coverage became effective (if not yet, when does it begin): _____ If coverage is no longer in effect, date that it ended: _____		
Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Chiropractic <input type="checkbox"/> Pharmacy					
Type of Policy <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B					
Persons Covered by Other Insurance					
Name		Date of Birth	Relationship to Policyholder	Name	