

OTHER INSURANCE INQUIRY

Name	
Soc Sec #	

Coordination of Benefits/Non Duplication Provision

Our plan(s) covering this patient contains a Coordination of Benefits and/or a Non Duplication provision. Before we can complete the processing of this claim we must determine whether you and/or your dependent(s) are covered under any other plan(s).

PLEASE ANSWER THE FOLLOWING QUESTIONS AND RETURN IMMEDIATELY:

1. Are you or any of your family covered by any other medical, dental or vision insurance plan?

() Yes () No

2. If YES, please provide the following:

A. Spouse's Employer: _____
Address: _____
Telephone: _____

B. Other insurance coverage:

1. You ()Medical ()Dental ()Vision
2. Your Spouse ()Medical ()Dental ()Vision
3. Your Children ()Medical ()Dental ()Vision

C. Date other coverage became effective: Month _____ Year _____

D. Spouse's Name: _____ Birth date __/__/__ Soc. Sec. #: _____

I certify that the above information is correct to the best of my knowledge.

Signature _____ Date ____/____/____

Please mail or fax to:

B&GCWA Insurance Trust
100 Court Ave, STE. 306
Des Moines, IA 50309
800-245-8813(phone) 515-244-8650(fax)