# OTHER HEALTH COVERAGE QUESTIONNAIRE

BlueChoice® HealthPlan
South Carolina

An independent licensee of the
Blue Cross and Blue Shield Association

Your contract contains a Coordination of Benefits (COB) provision to ensure correct benefits are provided on claims for members covered by more than one health insurance plan. We need information about possible other insurance coverage, including Medicare, before we can process your claims. Please complete this form and return it to the address listed on the bottom of this form. If you or a family member has Medicare or other coverage that has already provided benefits for these services, please attach the Explanation of Benefits notice to this form. If you have any questions or need help to fill out this form, please call the number listed on the back of your member ID card. Thank you for your cooperation.

I.D. Card #: _____ Name on ID Card: _____
First Name Last Name

| Your Spouse's Name: | Spouse's Social Security Number: | Spouse's Date of Birth: |
|---|---|---|
| Is your Spouse employed? Yes _____ No _____ | If your spouse is employed, please list the employer's name and telephone number: | |
| Are you actively at work? Yes _____ No _____ | If you are actively at work, your work schedule is: FULL-TIME _____ PART-TIME _____ | Date that you began work with current employer: |

Are you retired? Yes _____ No _____ If "yes," your retirement date:

Do you have group health insurance under continuation of coverage (COBRA)? If "Yes," please give the date that continuation under COBRA began:
Yes _____ No _____

Do you, your spouse, or dependent child(ren) have Medicare coverage? Yes _____ No _____

If "Yes," please list the names, dates of birth, Medicare ID Numbers, and effective dates of hospital and medical coverage for all family members who have Medicare because:

| They are age 65 or older: | They are disabled: | They have permanent kidney failure: |
|---|---|---|
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Are any family members disabled but not yet covered by Medicare? Yes _____ No _____
If "Yes," please list their names, dates of birth, and dates that disability began:

Do any family members have permanent kidney failure, but are not yet covered by Medicare? Yes _____ No _____
If "Yes," please list their names, dates of birth, and dates that kidney dialysis began:

Are you, your spouse, or dependent child(ren) covered by a group health plan other than this one? Yes _____ No _____
If "Yes," please furnish the following information:

| Name of Policyholder with other coverage: | Policyholder's relationship to you: | Name of other insurance company: |
|---|---|---|
| | | |

Check each type of service covered by the other plan: ☐ HOSPITAL ☐ PHYSICIAN/MEDICAL ☐ PRESCRIPTION DRUGS ☐ DENTAL CARE

Names of all family members covered by the other plan:

If divorced or separated, is there a court decree establishing financial responsibility for the health care expenses of the child(ren)? Yes_____ No_____

If "Yes," name of responsible person: _____

If "No," who has custody of the child(ren)? _____

CERTIFICATION: I certify that the information I have provided is complete, true, and correctly recorded to the best of my knowledge.

Your Signature: _____ Date: _____

PLEASE RETURN THIS FORM TO BLUECHOICE HEALTHPLAN, MAIL CODE AX-420, P.O. BOX 6170, COLUMBIA, SC 29260-6170 OR FAX TO 803-714-6443.

# Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

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Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

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Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

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Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

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Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

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Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

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あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

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اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)