



P.O. Box 100102, Columbia, SC 29202-3102
(803) 735-1251

OTHER 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 dental coverage plan. We need information about possible other dental coverage to process your claims correctly.

_____ **ID Number:** _____

_____ **Date:** _____

1. Do you or any dependents have any other group dental coverage? No Yes
IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM TO US OR CALL US AT 1-800-753-0404 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 dental policy.

For additional family members, attach sheet with information.

3. Name of other policyholder. _____

Other policyholder's date of birth _____ Relationship to you _____

4. Employer name if coverage is 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. _____

6. If there is a divorce or separation, please list who is responsible for the healthcare 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? _____

Your Signature _____ **Date** _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.