Other Insurance Company Information

In the pursuit of health®

Florida's Blue Cross and Blue Shield Plan

Member Name: ______________________________

Member ID Number: ______________________________

Please fill in the squares that apply to you.
If you have more than one insurance policy with other coverage, please complete a separate copy of this form.

SECTION A

Do you and/or a member of your family have other health or pharmacy insurance in addition to Florida Blue?	
☐ Yes, please complete sections B, C and E	☐ No, please complete section E
Do you and/or a member of your family have Medicare?	
☐ Yes, please complete sections D and E	☐ No, please complete section E

SECTION B: OTHER HEALTH OR PHARMACY INSURANCE INFORMATION

Name of Other Health or Pharmacy Insurance Company:

Other Insurance Street Address	City	State	Zip Code

Type of Insurance: **Employer Coverage**: ☐ Health ☐ Pharmacy ☐ Both
Individual Coverage: ☐ Health ☐ Pharmacy ☐ Both ☐ Medicare Supplement
☐ Medicare Advantage ☐ Other______________________________

RxBIN*: *for Pharmacy coverage only	PCN*: *for Pharmacy coverage only

Type of Coverage: ☐ Single ☐ Family ☐ Employee and Child Only
☐ Employee & Spouse Only ☐ Children Only ☐ Spouse Only

Name of Policyholder	Date of Birth	Policyholder's Sex	Employment Status
	| |	☐ Female ☐ Male	☐ Active ☐ Retired ☐ Cobra

Other Insurance Policy No.	Group #	Policyholder's Employer	Policy Effective Date	Other Policy Phone #
			| |	

If Employer coverage, how many employees? ☐ Less than 20 ☐ 20-99 ☐ 100 or more ☐ Unknown ☐ Not Applicable

Person Covered by Other Policy	Date of Birth	Relationship
1. ______________________	____/____/____	______________
2. ______________________	____/____/____	______________
3. ______________________	____/____/____	______________
4. ______________________	____/____/____	______________

SECTION C: Complete this section if you have dependent children affected by a divorce, legal separation, court-decreed custody/guardianship or child support order.

Does a court-decree state who has financial responsibility for providing health coverage for any dependent also covered by Florida Blue?
☐ No ☐ Yes, the court-decree specifies that ______________________________ has responsibility.
Name(s)/Relationship(s)

Child's Name	Custodial Parent Name and Date of Birth	Non-Custodial Parent Name and Date of Birth	Joint Custody Yes	Joint Custody No	Person with whom child lives
			☐	☐	
			☐	☐	
			☐	☐	

Please provide a copy of the insurance card or insurance information for each policy that covers the dependents listed above, if not already provided in Section B.

Please complete and sign the other side >

SECTION D: Medicare Coverage

Subscriber's Name	Sex ☐ Female ☐ Male	Medicare HIC No.	**Part A:** Effective Date / / Term Date / / **Part B:** Effective Date / / Term Date / / **Part D:** Effective Date / / Term Date / /
RxBIN*: *for Medicare Part D only		PCN*: *for Medicare Part D only	
Reason(s) for Medicare ☐ Age ☐ Disability ☐ End Stage Renal Disease	Date of First Dialysis Treatment / /	Location Treatment ☐ In Home ☐ Dialysis Facility	

Spouse or Dependent Name	Sex ☐ Female ☐ Male	Medicare HIC No.	**Part A:** Effective Date / / Term Date / / **Part B:** Effective Date / / Term Date / / **Part D:** Effective Date / / Term Date / /
RxBIN*: *for Medicare Part D only		PCN*: *for Medicare Part D only	
Reason(s) for Medicare ☐ Age ☐ Disability ☐ End Stage Renal Disease	Date of First Dialysis Treatment / /	Location Treatment ☐ In Home ☐ Dialysis Facility	

SECTION E: This section must be completed and signed by the subscriber.

Spouse's Name (If Applicable)	Date of Birth / /	Spouse's Social Security No. – –

Is your spouse employed and eligible for coverage through his/her employer? ☐ Yes ☐ No

If yes, did your spouse elect not to have coverage through his/her employer's group insurance? ☐ Yes ☐ No

To the best of my knowledge the information provided is true, accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier or plan to make available to Florida Blue all information concerning claims filed by me or on behalf of myself or my covered dependents.

________________________	___/___/___	(____) ________	(____) ________	___/___/___
Subscriber's Signature	Date of Birth	Work Phone No.	Home Phone No.	Today's Date

Thank you for completing this form.

You can send us your form by mail:

Florida Blue

OPL Dept.

PO Box 45287

Jacksonville, FL 32232-9805

Or fax to: 1-904-997-5224

FOR OFFICE USE ONLY:

Member ID Number: Department:

Group Number: Tracking Number:

Market Segment: