



1800 Ninth Avenue
PO Box 91015
Seattle, WA 98111-9115



Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

MULTIPLE COVERAGE INQUIRY

If you and/or your dependents have other insurance, or if coverage existed during the last six months, please complete this form and return it as soon as possible. This includes coverage by Regence BlueShield, any other BlueCross or BlueShield coverage, any other insurance company, any retirement plans or Medicare. Note: This form may be used for PEBB and SEBB Uniform Medical Plans.

Please sign and complete the form where indicated and submit the completed form to:

Regence BlueShield
Attn: UMP Claims
PO Box 91015 MS BU386
Seattle, WA 98111-9115
or by fax to: 1 (877) 357-3418

1. PLEASE ANSWER THIS QUESTION

Do you, or any family member covered by Uniform Medical Plan, have any other health insurance coverage or has any such coverage existed during the last six months? Include coverage by Regence BlueShield, any other company, any other Blue Shield or Blue Cross coverage, any retirement plan or Medicare.

- YES** If Yes, please fill out the rest of the form if there is other insurance (space has been provided on the back of this form for persons with more than one other health care plan).
- NO** If No, please sign and date the bottom of this form (Section 5), list your telephone number and ID number, and return the form to us as soon as possible.

2. OTHER INSURANCE INFORMATION (for Medicare, see Section 4)

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If coverage is no longer in effect, date that it ended: _____			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 (Please check all that apply.) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy			
Type of Policy (Please check all that apply.) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Supplement			

Persons Covered by Other Insurance

Name	Date of Birth	Relationship to Policyholder	Name	Date of Birth	Relationship to Policyholder

2a. ADDITIONAL OTHER INSURANCE INFORMATION (Complete if applicable. For Medicare, see Section 4)

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 (Please check all that apply.) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy			
Type of Policy (Please check all that apply.) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Supplement			

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

2b. ADDITIONAL OTHER INSURANCE INFORMATION (Complete if applicable. For Medicare see Section 4)

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 (Please check all that apply.) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy					
Type of Policy (Please check all that apply.) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Supplement					

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 (Please indicate if parents have dual custody.)		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	INCLUDE A COPY OF THE CHILD MAINTENANCE AGREEMENT FROM THE DIVORCE DECREE.
Address of Person With Financial Responsibility (Street or PO Box, City, State and Zip Code)			

4. Medicare: If you or any family member are covered by Medicare, please provide the following information.

Member's Name:		Medicare HIC Number:	
Part A Effective Date:		Part B Effective Date:	
If coverage began before age 65, please state the reason:			
Member's Name:		Medicare HIC Number:	
Part A Effective Date:		Part B Effective Date:	
If coverage began before age 65, please state the reason:			

Member's Name:	Medicare HIC Number:
Part A Effective Date:	Part B Effective Date:
If coverage began before age 65, please state the reason:	

5. SUBSCRIBER'S SIGNATURE

Subscriber's UMP ID Number	Date
Work Telephone	Home Telephone
Subscriber's Name (please print)	Subscriber's Signature