INSTIL® HEALTH

Visit our website at:
www.InStilHealth.com

OTHER HEALTH OR DENTAL COVERAGE QUESTIONNAIRE

Your contract includes a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than on health or dental coverage plan. We need information about possible other health or dental coverage, including Medicare, to process your claims correctly.

Name: _____ ID Card Number: _____

Address: _____ Date: _____
_____
_____

1. Do you or any dependents have any other group health, dental or Medicare coverage? ___ Yes ___ No

If no, please sign, date and return this form or call us at [insert number], and we will process this information immediately. If you answered yes, please proceed to the next question.

Signature: _____ Date: _____

2. Please list the family members covered by the other policy and select the type of coverage.

Name: _____ ___ Medical ___ Hospital ___ Drug ___ Dental ___ Medicare
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Name: _____ ___ Medical ___ Hospital ___ Drug ___ Dental ___ Medicare

3. Name of other policyholder: _____
   Date of Birth: _____ Relationship: _____

4. Employer's Name (If coverage is provider through an employer): _____
5. Name of Other Insurance Company: _____ Effective Date: _____
6. Other Insurance Company's Address: _____
   _____
   _____

7. Payor ID for Other Insurance Company (If known): _____
8. If divorce or separation, who is responsible for the health care expenses? _____
   If there is a copy of the divorce decree, please forward a copy to us.
   If there is no court decree, who has custody of the children? _____

******* THIS SECTION PERTAINS TO MEDICARE COVERAGE ONLY *******

9. Are you actively working? ___ Yes ___ No
   Start Date: _____
   Last Day of Active Employment: _____

10. Are you or any family members covered by Medicare? ___ Yes ___ No

If yes, please complete the following information:

Name: _____ Date of Birth: _____
Medicare Number: _____ Part A Effective Date: _____
Part B Effective Date: _____

Reason for Medicare (Check one): ___ Age ___ Disability ___ ESRD: Date of First Dialysis: _____

Name: _____ Date of Birth: _____
Medicare Number: _____ Part A Effective Date: _____
Part B Effective Date: _____

Reason for Medicare (Check one): ___ Age ___ Disability ___ ESRD: Date of First Dialysis: _____

Name: _____ Date of Birth: _____
Medicare Number: _____ Part A Effective Date: _____
Part B Effective Date: _____

Reason for Medicare (Check one): ___ Age ___ Disability ___ ESRD: Date of First Dialysis: _____

Signature: _____ Date: _____

Please mail or fax this form to:

Instil Health
P.O. Box 100324
Columbia, SC 29202-3324
Fax: 803-870-8351