LIFEWISE
ASSURANCE COMPANY

PO Box 91059
Seattle, WA 98133-0940

Other Coverage Questionnaire Enrollment

Customer Service: 800-971-1491
Hearing Impaired: 800-842-5357

Dear Subscriber:

We appreciate your assistance in providing information about other health coverage you may have — thank you for your cooperation! Please either review this form and call Customer Service at 1-800-971-1491 with the information or complete the form and mail to the address above.

Subscriber Name and Address

_____

_____

_____

Date _____

Member ID _____

Group Number _____

Group Name _____

OTHER COVERAGE INFORMATION

Do you or any family members have any of the following:

Other medical, dental, prescription drug, or vision coverage? ☐ No ☐ Yes

If Yes, please complete the following sections. If more than one policy or plan, please attach additional paper.

IF ANOTHER HEALTH PLAN PAYS FIRST, SEND US A COPY OF ITS EXPLANATION OF BENEFITS.

OTHER INSURANCE COMPANY OR PLAN:	NAME OF POLICYHOLDER	DATE OF BIRTH MONTH DAY YEAR
COMPANY NAME	RELATIONSHIP TO OUR SUBSCRIBER	
STREET ADDRESS	IS PLAN A GROUP COVERAGE? ☐ NO ☐ YES IS THIS COBRA COVERAGE? ☐ NO ☐ YES IS COVERAGE AN INDIVIDUAL PLAN? ☐ NO ☐ YES	
CITY, STATE, ZIP CODE	PLAN ID # (SOCIAL SECURITY #, MEMBER #, ETC.)	
TELEPHONE NUMBER ( )	GROUP #	
EFFECTIVE DATE OF COVERAGE	EMPLOYER: ARE YOU RETIRED? ☐ NO ☐ YES	
	ABOVE PLAN IS FOR: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUGS	
	ABOVE PLAN COVERS: ☐ SUBSCRIBER ☐ SPOUSE ☐ DEPENDENT CHILDREN ☐ DOMESTIC PARTNER	

Medicare coverage ☐ No ☐ Yes If Yes, please complete the following sections. If there is more than one member with Medicare Coverage, use a separate piece of paper. **Please include a copy of your Medicare card(s) for each Medicare recipient.**

NAME OF FAMILY MEMBER WITH MEDICARE COVERAGE		MEDICARE ID NUMBER	PART A EFF. DATE	PART B EFF. DATE	PART D EFF. DATE
			/ /	/ /	/ /
RETIREMENT DATE	**ARE YOU ENTITLED TO MEDICARE DUE TO ONE OF THE FOLLOWING:**	**DATES REQUIRED IF DISABILITY OR KIDNEY FAILURE CHECKED:**	**DATE OF ENTITLEMENT**	**FIRST DIALYSIS TREATMENT**	**KIDNEY TRANSPLANT**
/ /	☐ DISABILITY ☐ KIDNEY FAILURE		/ /	/ /	/ /
Are you entitled to Medicare for more than one reason? If so, give the reasons for your dual entitlement:					

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SIGNATURE OF SUBSCRIBER

X

IMPORTANT REMINDERS

- When we request Other Coverage information, please return the form by the date indicated to ensure prompt processing of your bill(s).
- Always keep your health care providers (doctor, dentist, etc.) updated with your correct health care coverage information.