BPA Benefit Plan Administrators
402 Graham Avenue • PO Box 1128 • Eau Claire, WI 54702-1128 PHONE: (800)236-7789 • (715)832-5535 • FAX: (715)838-8507

OTHER COVERAGE QUESTIONNAIRE

Employer Name: _____

Employee Name: _____
Last First M

Employee Member ID: _____

Spouse's Name: _____
Last First M

Dependent Name(s): _____

_____

1) Do any of the family members listed above have Medicare?

☐ NO (If no, continue to question #2)

☐ YES (If yes, please complete the following and enclose a copy of the card with this completed form.)

List the names of each covered individual _____

Effective Date of Coverage: Part A _____ Part B _____

2) Do any of the dependents listed above have other Insurance currently in effect?

☐ NO (If no, enter prior coverage term date below, complete the signature and return to address on form or contact BPA Customer Service at 1.800.236.7789 to update.)

☐ YES (If yes, please complete the following and enclose a copy of the card with this completed form.)

List the names of each covered individual _____

_____

Policyholder Name: _____ Policyholder Date of Birth: _____

Name of other insurance company _____

Check type of Insurance: ☐ Group/Self Insurance ☐ Medicaid (State Insurance)

Effective Date of Coverage _____ Prior Coverage Term Date _____

Name of Custodial Parent or Joint Custody Parents:_____

Check all of the benefits provided under the other group plan:

☐ Medical ☐ Drug Card ☐ Dental ☐ Vision

I certify that the above statements are true and complete to the best of my knowledge.

Signature of Employee _____ Date _____