



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**

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_  
Last First M

Employee Unique ID: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
Last First M

Dependent Name(s): \_\_\_\_\_  
\_\_\_\_\_

1) Do any of the family members listed above have Medicare or are eligible for 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 family members listed above have other group insurance currently in force?

NO (If #1 and #2 are both no, complete the signature below and return or please feel free to contact BPA Customer Service at 1.800.236.7789 to provide this information.)

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 \_\_\_\_\_

Group ID number \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

Name of Custodial Parent \_\_\_\_\_

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