



BlueAdvantage Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 1460
Little Rock, AR 72203

Dear Customer,

We need your help updating our records. When you or family members have health insurance through more than one company, benefits must be coordinated to avoid overpayment. Please complete the following questionnaire and return it to our office in the enclosed envelope. Claim payments will be delayed until this form is received.

Employee Name: _____ ID#: _____

Do you or any members of your family have health insurance through a company other than BlueAdvantage Administrators? Yes _____ No _____

If you responded YES, please complete the remaining portion of this form.

Your Spouse's information: Name of Insurance Company: _____

Coverage includes: Medical _____ Dental _____ Both _____

Effective Date of Coverage: _____ Termination Date (if applicable) _____

Spouse's Name: _____ Spouse's DOB: _____

Social Security Number: _____ Spouse's Employer: _____

Is spouse a current, active employee? Yes _____ No _____ If no, please provide retirement date: _____

Your Dependents' information: Name of Insurance Company: _____

Coverage includes: Medical _____ Dental _____ Both _____

Effective Date of Coverage: _____ Termination Date (if applicable) _____

List dependents covered by other coverage:

<u>Name</u>	<u>Date of Birth</u>	<u>Name</u>	<u>Date of Birth</u>
_____	_____	_____	_____
_____	_____	_____	_____

Has coverage for your dependent children been affected by a Divorce Decree or by custody?

No _____ Yes _____ (If yes, please include a copy of the first page from the Divorce Decree and all pages that apply to health coverage.)

Are you, your spouse, or dependents covered by Medicare? Yes _____ No _____

Name of Medicare participant: _____

Medicare #: _____ Medicare Effective Date: _____

Reason for Medicare coverage: Over 65 _____ Disabled _____ Kidney Disease _____

Sincerely,
BlueAdvantage Administrators
Customer Service Division
800-370-5792

Signature/Date: _____