BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

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# Request For Other Coverage Information

Associate Name:
Street Address:
City/State/Zip:

Identification #:

Email address _____

Telephone # _____

**Associate Marital Status:**

- ☐ Single/Never Married
- ☐ Married:
  Date of
  Marriage_____
- ☐ Legally Separated
- ☐ Divorced
- ☐ Domestic Partnership

## Section A – Other Insurance Status

- ☐ I am currently enrolled for coverage through another medical insurance policy or Medicare(if checked, complete section B)
- ☐ My spouse, domestic partner and/or dependent(s) do have other medical insurance (complete section B for spouse and C for dependents).
- ☐ My spouse, domestic partner, dependent(s), and I do not have any other medical insurance (sign and return).

## Section B – Other Insurance Information about You and/or Your Spouse

(Complete this section if you or your spouse/domestic partner are enrolled for coverage through another insurance policy.)

<table>
<tr><td colspan="2">Policyholder's Full Name (Last, First, Middle)</td><td>Date of Birth (MM/DD/YY)</td><td>Gender<br>☐ Male ☐ Female</td></tr>
<tr><td colspan="2">Name of Other Insurance Company</td><td colspan="2">Employer or Group Name</td></tr>
<tr><td colspan="2">Type of Coverage (Check all that Apply)<br>☐ Medical ☐ Vision ☐ Dental ☐ Medicaid<br>☐ Medicare A ☐ Medicare B</td><td colspan="2">Medicare Reason:<br>☐ Age ☐ Disability ☐ ESRD<br>First Date of Dialysis: _____</td></tr>
<tr><td colspan="4">Insurance Company Address</td></tr>
<tr><td colspan="2">Other Insurance Company's Telephone<br>[ ] -</td><td colspan="2">Other Insurance Policy/Identification Number</td></tr>
<tr><td>Effective Date of Coverage</td><td>Cancellation Date<br>(if applicable)</td><td colspan="2">Policy Status:<br>☐ Active ☐ Retired ☐ COBRA<br>Retirement/COBRA Begin Date: _____</td></tr>
<tr><td colspan="4">Other Policy Covers: (Check One)<br>☐ Policyholder Only ☐ Policyholder and Spouse/ Domestic Partner ☐ Policyholder and Children ☐ Family</td></tr>
</table>

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## Section C – Other Insurance Information about Your Dependent(s)

(Complete this section if your dependents are covered through another insurance policy.)

| Dependent(s) Name | Date of Birth | Effective Date of Insurance | Cancellation Date (if applicable) | Policy/ID # |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Name of Other Insurance Policyholder | Policyholder Date of Birth (MM/DD/YY) |
|---|---|
| Relationship of Policyholder to Dependent(s) | |
| Other Insurance Responsible due to ☐ Custody ☐ Divorce Decree* ☐ Child Support Order*<br>*Please enclose a copy of the section of the decree that establishes financial responsibility for medical care. | |
| Name of Other Insurance Company | Other Insurance Company's Telephone |

CERTIFICATION:
I hereby certify that the above information is true, complete and correct

Associate's Signature and Date

BlueAdvantage Administrators of Arkansas is in the process of updating subscriber information. You may submit the information in a variety of ways:

- Mail this form in the pre-addressed envelope provided
- Email WalMartServiceTeam-BlueAdvClms@arkbluecross.com
- Fax this form to (501) 378-3015
- Call Customer Service at (866) 823-3790