Group: PM085516

CEBT Other Insurance Questionnaire

Enrollee Name: ______________________ *Member ID Number:* ____________

Providing other insurance information to UMR before a claim is submitted will allow your claims to be processed more quickly. Once our records have been updated, UMR will only request the information annually, unless there is a change in the information.

Other Insurance Information

Do you or any covered family participants have coverage other than your CEBT coverage?

Medical ☐ YES ☐ NO Dental ☐ YES ☐ NO Vision ☐ YES ☐ NO

If yes to any of the above, please provide information about the other coverage:

Insurance Company Name: ____

Type of Coverage: Medical Y / N Dental Y / N Vision Y / N

Telephone Number (____) ____-______ Policy or Group Number ______________

Effective Date of Coverage: ___/___/_____

Please provide information about the person who carries other coverage:

Name: ______________________________________ Date of Birth ___/___/______

Social Security or ID Number: __________________ Relationship to: ____________

If other coverage is provided by an Employer Plan, please provide the Employee Name:

____________________________ Employee Actively at Work? ☐ YES ☐ NO

If the above coverage is Medicare, please indicate the type of coverage:

____ Part A (Inpatient Hospital) Effective Date ___/___/______

____ Part B (Outpatient/Medical) Effective Date ___/___/______

Names and effective dates of coverage for each dependent (if any) covered by plan described above:

Full Name	Effective Date of Coverage
____	___/___/______
____	___/___/______
____	___/___/______

I certify that the above information is true and complete.

Signature of Enrollee ________________________________ Date _____________

Day Time Telephone Number (if additional information is needed) (____) ____-________

Please return the completed form to:

Fax (608) 783-8621 Or Mail to: UMR
2700 Midwest Drive
Onalaska, WI 54650