

Other Insurance Information

Name of member covered by other insurance:	Subscriber Name:				
() YES () NO 2) If you answered "YES" to question No. 1, complete the information below: Name of member covered by other insurance: Employer: Insurance Company: Insurance Company Telephone Number: Effective Date of Coverage: Policy Holder: Relationship of Insured to Policy Holder: Contract/ID#: Coverage type: () Family () YES () NO If YES" complete the questions below: Medicare ID Date of Birth Medicare Part A Image: Coverage type: Medicare Part A Image: Coverage type: Medicare Part B Image: Coverage type: Medicare Part C Image: Coverage type: Medicare Part C Image: Coverage type: Medicare Part D Image: Coverage type: Medicare Part D Image: Coverage type: Medicare Part C Image: Coverage: Coverage type: Medicare Part C Image: Coverage: Coverage: Coverage: Coverage: Coverage: Coverage: Coverage: C	Subscriber Identification Number	r:			
Employer:		policy have	other medical or denta	linsurance?	
Employer:	2) If you answered "YES" to question	No. 1, com	plete the information be	elow:	
Insurance Company:	Name of member covered by othe	er insurance	:		
Insurance Company Telephone Number:	Employer:				
Effective Date of Coverage: Policy Holder: Relationship of Insured to Policy Holder: Contract/ID#: Coverage type: () Family () Individual () Retired 3) Are you or any member under your policy covered by Medicare? () YES () NO If "YES" complete the questions below: Medicare ID Date of Birth Name Please check all that apply: Yes/No Effective Date Termination Date Medicare Part A Medicare Part B Medicare Part B Medicare Part C Medicare Part C Medicare Part D Are you/they disabled? () YES () NO Do you/they have End Stage Renal Disease (ESRD)? () YES () NO If "YES" complete: Name(s) of children:	Insurance Company:				
Policy Holder:	Insurance Company Telephone N	umber:			
Relationship of Insured to Policy Holder:	Effective Date of Coverage:				
Contract/ID#:	Policy Holder:				
Coverage type: () Family () Individual () Retired 3) Are you or any member under your policy covered by Medicare? () YES () NO If "YES" complete the questions below:	Relationship of Insured to Policy H	Holder:			
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Medicare Part A Medicare Part B Medicare Part C Medicare Part D Are you/they disabled? () YES () NO Do you/they have End Stage Renal Disease (ESRD)? () YES () NO If "YES" complete: Name(s) of child or children:	Medicare ID	Date of Birth		Name	
Medicare Part B Medicare Part C Medicare Part D Are you/they disabled? NO Do you/they have End Stage Renal Disease (ESRD)? Is any family member covered by a court decree? Is any family member covered by a court decree? If "YES" complete:		Yes/No	Effective Date	Termination Date	
Image: Medicare Part C Image: Medicare Part D Image: Medicare Part D Image: Medicare Part D Are you/they disabled? () YES () NO Do you/they have End Stage Renal Disease (ESRD)? () YES () NO Is any family member covered by a court decree? () YES () NO If "YES" complete: Name(s) of child or children: Image: Mame(s)					
Are you/they disabled? () YES () NO Do you/they have End Stage Renal Disease (ESRD)? () YES () NO 4) Is any family member covered by a court decree? () YES () NO If "YES" complete: Name(s) of child or children:					
Do you/they have End Stage Renal Disease (ÈSRD)? () YES () NO 4) Is any family member covered by a court decree? () YES () NO If "YES" complete: Name(s) of child or children:	Medicare Part D				
If "YES" complete: Name(s) of child or children:		,		() NO	
I certify to the best of my knowledge, the information provided above is true and correc	If "YES" complete: Nam Resp	e(s) of chilc onsible Part	l or children: y(ies):		

Subscriber Signature

Date

Please return completed form to: Farm Bureau Health Plans P.O. Box 1424 Columbia, TN 38402-1424