



Other Insurance Information

Subscriber Name: _____

Subscriber Identification Number: _____

1) Does any member covered on this policy have other medical or dental insurance?
 () 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 () 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
<input type="checkbox"/>	Medicare Part A		
<input type="checkbox"/>	Medicare Part B		
<input type="checkbox"/>	Medicare Part C		
<input type="checkbox"/>	Medicare Part D		

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: _____
 Responsible Party(ies): _____

I certify to the best of my knowledge, the information provided above is true and correct.

Subscriber Signature

Date

Please return completed form to: Farm Bureau Health Plans
 P.O. Box 313
 Columbia, TN 38402-0313