LifeWise Assurance Company

PO Box 91059
Seattle, WA 98111-9159

Other Coverage Questionnaire Enrollment

Customer Service: 800-971-1491
Hearing Impaired: 800-842-5357

Dear Subscriber:

We appreciate your assistance in providing information about other health coverage you may have — thank you for your cooperation! Please either review this form and call Customer Service at 1-800-971-1491 with the information or complete the form and mail to the address above.

Subscriber Name and Address

_____

_____

_____

Date _____

Member ID _____

Group Number _____

Group Name _____

OTHER COVERAGE INFORMATION

Do you or any family members have any of the following:

Other medical, dental, prescription drug, or vision coverage? ☐ No ☐ Yes

If Yes, please complete the following sections. If more than one policy or plan, please attach additional paper.

IF ANOTHER HEALTH PLAN PAYS FIRST, SEND US A COPY OF ITS EXPLANATION OF BENEFITS.

OTHER INSURANCE COMPANY OR PLAN:	NAME OF POLICYHOLDER	DATE OF BIRTH MONTH DAY YEAR
COMPANY NAME	RELATIONSHIP TO OUR SUBSCRIBER	
STREET ADDRESS	IS PLAN A GROUP COVERAGE? ☐ NO ☐ YES IS THIS COBRA COVERAGE? ☐ NO ☐ YES IS COVERAGE AN INDIVIDUAL PLAN? ☐ NO ☐ YES	
CITY, STATE, ZIP CODE	PLAN ID # (SOCIAL SECURITY #, MEMBER #, ETC.)	
TELEPHONE NUMBER ( )	GROUP #	
EFFECTIVE DATE OF COVERAGE	EMPLOYER: ARE YOU RETIRED? ☐ NO ☐ YES	
	ABOVE PLAN IS FOR: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUGS	
	ABOVE PLAN COVERS: ☐ SUBSCRIBER ☐ SPOUSE ☐ DEPENDENT CHILDREN ☐ DOMESTIC PARTNER	

Medicare coverage ☐ No ☐ Yes If Yes, please complete the following sections. If there is more than one member with Medicare Coverage, use a separate piece of paper. **Please include a copy of your Medicare card(s) for each Medicare recipient.**

NAME OF FAMILY MEMBER WITH MEDICARE COVERAGE		MEDICARE ID NUMBER	PART A EFF. DATE	PART B EFF. DATE	PART D EFF. DATE
			/ /	/ /	/ /
RETIREMENT DATE	**ARE YOU ENTITLED TO MEDICARE DUE TO ONE OF THE FOLLOWING:**	**DATES REQUIRED IF DISABILITY OR KIDNEY FAILURE CHECKED:**	**DATE OF ENTITLEMENT**	**FIRST DIALYSIS TREATMENT**	**KIDNEY TRANSPLANT**
/ /	☐ DISABILITY ☐ KIDNEY FAILURE		/ /	/ /	/ /
Are you entitled to Medicare for more than one reason? If so, give the reasons for your dual entitlement:					

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SIGNATURE OF SUBSCRIBER

X

IMPORTANT REMINDERS

- When we request Other Coverage information, please return the form by the date indicated to ensure prompt processing of your bill(s).
- Always keep your health care providers (doctor, dentist, etc.) updated with your correct health care coverage information.

LifeWise
Assurance Company

Discrimination is Against the Law

LifeWise Assurance Company (LifeWise) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-971-1491 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-971-1491（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-971-1491 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-971-1491 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-971-1491 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-971-1491 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-971-1491 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-971-1491 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-971-1491（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-971-1491 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-971-1491 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-971-1491 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-971-1491 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-971-1491 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-971-1491 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-971-1491 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-971-1491 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-971-1491 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-971-1491 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-971-1491 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-971-1491 (TTY: 711) تماس بگیرید.

037404 (11-06-2019)