



**FAILURE TO PROVIDE THIS INFORMATION WILL
RESULT IN CLAIM PROCESSING DELAYS**

Other Coverage Inquiry

TML MultiState Intergovernmental Employee Benefits Pool (IEBP) is in receipt of a claim for you, (or your dependent under age 18 years of age) and in order to consider your claim we require information regarding other health coverage. Health coverage includes Medical, Prescription, Dental and/or Vision coverage. Please promptly complete and return this form to the address below to avoid delays in claim adjudication or provider prompt pay penalties.

If you have already completed or submitted this form to IEBP, please contact Customer Care for verification that your completed form has been received before you resend.

TML MultiState IEBP Contact Information

Mail to: TML MultiState IEBP
PO Box 149190
Austin, TX 78714-9190
Fax to: (512) 719-6539
Online at: www.iebp.org/survey/

For questions or assistance with this form contact Customer Care:

- » **Call:** (800) 282-5385 or
- » **E-mail:** www.iebp.org | click on the "Login" button | click on "Online Customer Care" under the "My Tools" menu
- » **Telefónica en Español:** (800) 385-9952

Employee/ Subscriber Name: _____	Employee/ Subscriber ID: _____
Employer Name: _____	Group #: _____

1. Do you, your spouse or your dependents that are covered under your plan also have coverage through another medical, prescription, dental and/or vision plan (currently or within the last 12 months)? Yes No
2. Do you, your spouse or your dependents expect to be covered under an additional medical, prescription, dental and/or vision plan during the next 12 months (e.g. resulting from a change in work status, marital status, open enrollment, or Medicare eligibility)? Yes No

If you have answered no to both questions, please sign the form and return it to the address indicated.

If you have answered **Yes** to either question #1 or #2, please list everyone, (including yourself) covered under the other plan that is also covered under your employer plan:

Name	Date of Birth	Carrier Name	Type of Coverage*	Effective Date	Termination Date

*Types of Coverage: Medical, Prescription, Dental and/or Vision

See back of form for additional questions.

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Other Coverage Plan Details

Type of Plan

- Employer plan
 - PPO
 - HMO
 - High Deductible Health Plan with Health Savings Account (H.S.A.)
 - Health Reimbursement Plan/HRA (General Purpose)
 - Health Reimbursement Plan/HRA (Post Deductible - limited)
 - Section 125 Plan
 - Other _____

Type of Plan (continued)

- Medicare
- Medicaid
- SCHIP
- Individual plan

3. Are any of your dependents covered under more than one medical, prescription, dental and/or vision plan belonging to parents or legal guardians who are divorced, separated or not living together? Yes No

If yes, list the dependents and the parent that the dependents reside with for the majority of the year, and answer question #4: _____

4. Do any court documents exist that pertain to the parental responsibilities of your dependents covered by the TML MultiState IEBP employer plan?

Yes No (If yes, please submit a copy of the entire court document if not previously submitted.)

5. Please submit a copy of both sides of your medical health benefit enrollment card(s) **OR** complete the following information regarding the other plan coverage (include details regarding all other plans on an additional form, if needed).

Effective date of other coverage:	Other coverage plan name:	Other coverage plan address:
Termination date of other coverage, (if applicable):		
Other coverage plan phone number:	Other coverage plan number:	Other coverage benefit subscriber name:
Other coverage benefit subscriber ID number:	Other coverage benefit subscriber date of birth:	Other coverage benefit subscriber relationship to TML MultiState IEBP covered individual:

I hereby certify that the above information is correct.

Employee Signature

Date

PLEASE NOTE: YOU WILL NEED TO COMPLETE A NEW "OTHER COVERAGE INQUIRY" FORM EACH TIME YOU OR YOUR DEPENDENTS HAVE A CHANGE IN HEALTH BENEFIT COVERAGE.