bac

OTHER INSURANCE COVERAGE(S)

PLEASE COMPLETE THE INFORMATION BELOW TO SPECIFY IF ANY MEMBER ON YOUR POLICY HAS OTHER INSURANCE. **THEN RETURN THIS FORM BY FAX TO 614-863-0184, EMAIL TO BACINFOREQ@BACTPA.COM OR SUBMIT IT VIA OUR PORTAL AT BACTPA.VBAGATEWAY.COM**

A. MEMBER'S INFORMATION:

BAC MEMBER'S NAME (LAST, FIRST, M.):

BAC MEMBER ID NUMBER:

MEMBER'S ADDRESS:

CITY:

STATE:

ZIP CODE:

EMPLOYER'S NAME:

MEMBER'S EMAIL ADDRESS (USER@DOMAIN.COM):

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER INSURANCE:

◯ **NO** ◯ **YES, PLEASE COMPLETE SECTION B**

B. COMPLETE ONCE FOR EACH DEPENDENT COVERED BY ANOTHER INSURANCE PLAN

INSURED'S NAME (LAST, FIRST, M.):

INSURED'S D.O.B. (MM/DD/YYYY):

NAME OF INSURED'S EMPLOYER:

TYPE OF COVERAGE?

◯ **MEDICAL** ◯ **DENTAL**

NAME OF INSURANCE COMPANY:

ADDRESS OF INSURANCE COMPANY:

INSURED'S SOCIAL SECURITY NUMBER:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

NAMES OF ALL OTHER DEPENDENT'S COVERED UNDER THIS POLICY (LAST, FIRST, M.):

IS THIS INSURANCE REQUIRED BY A COURT ORDER?

◯ **NO** ◯ **YES, PLEASE ATTACH A COPY OF THE COURT ORDER**

C. SIGNATURE:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

X _____ _____

SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.