Other Dental Insurance coverage Questionnaire

UNITED CONCORDIA®

••• SECTION A-OTHER INSURANCE SECTION•••

Type of Plan: ☐ Group ☐ Supplemental ☐ Medicaid ☐ Reduced Fee Plan
Insured's Name: Insured's Policy Number:
Insurance Company Name: Insured's Birthdate:
Effective Date: Cancel Date (if applicable):
Phone Number of Other Insurance:

List Family Members Covered by Plan:

NAME	RELATION TO INSURED (Example: child, stepchild, spouse)	BIRTHDATE

••• SECTION B-IF PARENTS DIVORCED, SEPARATED, OR NEVER MARRIED•••

Before completing, please review the coordination of benefits information on page 3.

1. If there is a COURT ORDER or SUPPORT ORDER specifying which parent is responsible for dental or medical coverage, please provide the following information then skip to SECTION C:

   List the parent who is to be responsible for the insurance:
   List the child/children this document applies to:

2. If you do not have a court order or support order specifying which parent is responsible, is legal custody of the child/children:
   ☐ JOINT (Both parents are responsible for decision-making and may share physical custody)
   ☐ SOLE (One parent has the right to make decisions and the child resides with them)

   A. IF JOINT: (Please complete)
      Natural Mother's Name and Birthdate:
      Natural Father's Name and Birthdate:

   B. IF SOLE: (Please complete)
      Name of parent with sole custody:
      Name of child/children:
      Is the parent with majority custody remarried?
      If yes, does the stepparent have dental coverage for the child/children?
      If yes, complete the following:
      Name of stepparent:
      Insurance Company Name
      Name of child/children covered under this plan:

••• SECTION C -POLICY INFORMATION•••

Member's Name: Member's SSN:
List Dependent Child/Children Covered by the Plan and their relationship lo the member:

NAME	RELATION TO TDP SPONSOR (Example: child, stepchild, spouse)	BIRTHDATE

The statements made above are true and accurate to the best of my knowledge. I understand that federal laws 18 U. S. C. 287 and 1001 provide for criminal penalties for submitting knowingly or making false, fictitious or fraudulent statements or claim in any manner within the jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefits Advisors. Because personal information is being requested from you, we are required by the Privacy Act of 1974, to notify you of the following: This information is requested under authority of Chapter 55, Title 10, United States Code, Section 1076a. The information is requested to establish or update information in order to process dental claims for payment. Routinely, this information will be used to determine eligibility for benefits, review and approve dental care, and to determine charges to be cost-shared. Disclosure is voluntary; however, failure to provide information will result in denial of, or delay in payment of the claim.

YOUR NAME YOUR PHONE NUMBER

YOUR SIGNATURE DATE

If you have any questions or need assistance completing this form, please call 1-844-653-4061.

You can submit this form two ways:
1. Email. Attach the completed form to the "Contact Us" form located in the "Contact Us" tab at www.uccitdp.com.
2. Mail. Mail the completed form to: TDP Customer Service, PO Box 69450 Harrisburg, PA 17106

If you need additional information, see pages 38-39 of the TDP Handbook located at www.uccitdp.com in the Forms & Materials tab.