



PGBA, LLC

TRICARE OTHER HEALTH INSURANCE (OHI) COVERAGE QUESTIONNAIRE

1. General Information

TRICARE Sponsor Name: _____

TRICARE Sponsor SSN: _____

Do you or any of your family members have OHI coverage? YES___ NO___

Have you or any of your family members had OHI in the past 12 months? YES___ NO___

If you answered yes to question 1 or 2 above, please complete the remainder of the form (duplicate form for multiple policies). Regardless of your answers above, please read and sign the form at the bottom and submit the form to the address below.

2. Current OHI Status - Complete only if you or any of your family members currently have OHI.

Policy Holder Name: _____ Policy Number: _____

Name of Carrier: _____

Carrier's Address and Phone No: _____

Effective Date: _____ Expiration Date: _____

Please indicate type of coverage: HMO/PPO___ Single___ Group___ Private___ Medicare___ Supplemental___

Medicaid/MediCal___ Other: _____

Does this coverage have pharmacy benefits? ___ Yes ___ No

Does this coverage have any other benefit riders? ___ Yes ___ No

If yes, please indicate which one(s): _____

Name of Covered Member:	Member ID:	Date of Birth:	Sex:	Effective:	Expiration: (if different)
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____

