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)
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____

PGBA, LLC

---

3. Prior OHI Status - Complete only if you or any of your family members have had OHI within the last 12 months, but do not have coverage now.

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)
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____

The statements made above are true and correct to the best of my knowledge. I understand that federal laws [8 U.S.C. and 100] provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims on any matter 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 Benefit Advisors.

_____ _____ _____
Your Signature Relationship to TRICARE Sponsor Date

If mailing OHI with Prime Enrollment form, mail to:

Humana Military Healthcare Services
PO BOX 740061
Louisville KY 40201-7461

Fax (866)836-9535

If mailing OHI form separately, mail to:

TRICARE South Region
Customer Service Dept.
PO Box 7032
Camden, SC 29020-7032