

COORDINATION OF BENEFITS

Member's name: _____

Member's address: _____

Member's Social Security #: _____

We recently received an enrollment card that indicated you may have other insurance available to you or your family members. Please complete the following questionnaire if you or your family currently have or has had other medical insurance within the past 12 months.

Do you or any member of your family have other health insurance? _____ YES _____ NO. If yes please continue. If no, please sign, date and return this form in the envelope provided.

In whose name is the other policy _____ Their date of birth ____/____/____
MM DD YYYY

The other policy covers: ___Hospital ___Medical ___Dental ___Vision ___Drug
Policyholder status: ___Active ___Retired ___COBRA (Continuation of coverage)

Policy Type: ___Family ___Single Group Number _____

Policy Number _____ Effective Date _____ Cancellation Date _____

Name of Insurance Company _____

Street Address _____

City, State Zip _____ Telephone # _____

If the other insurance is Family coverage, list the names, birth dates and relationships of those covered under this policy. If there is a court order designating responsibility for a child's health care, please attach a copy of that document to your response.

Last Name	First	MI	Birth date	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If Medicare covers you: Effective Date of Part A _____ Part B _____ Part D _____
Due to: Age Disability End Stage Renal

If Medicare covers your: Spouse Other Dependent
Their Name: _____ Medicare # _____
Effective Date of Part A _____ Part B _____
Due to: Age Disability End Stage Renal

This information is true and complete to the best of my knowledge.

Member Signature

Date

Home Phone