

COORDINATION OF BENEFITS FORM

Please return form within 20 days

Subscriber's Name:

ID#:

SSN:

Group:

Marital Status Single Married Divorced Separated

I. DEPENDENTS (covered under our health plan):

Spouse's Social Security Number _____ Date of Birth _____

Spouse's Place of Employment _____

Address _____

| CHILDREN: | Name | Date of Birth | Relation | |
|-----------|------|---------------|------------------|--------------------|
| (First) | (MI) | (Last) | (Month/Day/Year) | (Child, Stepchild) |

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

II. GROUP HEALTH COVERAGE/COMMERCIAL INS

A. Are you, your spouse, or dependent children covered by any other group insurance?

YES NO If "Yes," please list: Insurer _____

Contract or Policy Number _____ Group Number _____

Name of Insurance Company _____

Address _____

Through what group or organization is this coverage available? _____

Does this policy cover you? YES NO

Your Spouse? YES NO

Your Children? YES NO

Does this policy include dental coverage? YES NO

Does this policy include vision coverage? YES NO

What is the effective date of policy? _____

III. FOR DEPENDENTS OF DIVORCED PARENTS:

Which parent has custody of the dependent children? _____
Mother/Father Name

Does divorce decree establish medical responsibility for the dependent children?
___ YES ___ NO Which Parent? _____
Mother/Father Name

IV. MEDICARE OR GOVERNMENT SPONSORED

Are you, your spouse, or dependent children covered by Medicare or any other government sponsored care program? ___ YES ___ NO If "Yes," please list:

| | <i>Subscriber</i> | <i>Spouse</i> | <i>Dependent</i> |
|---|-------------------|---------------|------------------|
| <i>Claim Number</i> | _____ | _____ | _____ |
| <i>Hospital Insurance (Part A) Effective Date</i> | _____ | _____ | _____ |
| <i>Medical Insurance (Part B) Effective Date</i> | _____ | _____ | _____ |
| <i>Retirement Date (if applicable)</i> | _____ | _____ | _____ |

Has Medicare due to: ESRD ___ Age ___ Disability ___ Dependent ___

V. CERTIFICATION

I certify that, except as indicated above, no service or payments are provided or are recoverable through any other group insurance or service plan.

Subscriber's Signature: _____ Date: _____