Coordination of Benefits Questionnaire

Policyholder Name

Group Number | Member ID Number

Section A | Other Insurance *If this does not apply, skip to Section B.*

☐ **No** If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ **Yes** If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply: ☐ Other Health Insurance ☐ Other Dental Insurance

What type of policy is this? ☐ Group ☐Individual Policy ☐Student Policy ☐Medicare Supplemental

Other Insurance Carrier's Name

Address

City | State | Zip | Phone Number

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name | Policyholder's Date of Birth | ID Number

Effective Date of Other Insurance | If Canceled, Cancellation Date

Is the policyholder: ☐ Actively working for the group ☐ Inactive

☐ Retired, retirement date: _____ ☐ On COBRA, which began_____

Policyholder's Employer

Address

City | State | Zip | Phone Number

Section **B** | **Medicare Information** *If this does not apply, skip to Section C.*

Do the policy holder and/or dependent(s) have Medicare? ☐ **Yes** ☐ **No**

| _____

Name of person(s) with Medicare

| _____

Medicare Number, including alpha character(s)

Effective Date of Medicare Part A:_____ Effective date of Medicare Part B:_____

Medicare Entitlement: ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)*

*If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability:_____

1st Date of Dialysis for ESRD:_____

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis of Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If yes, please provide the date of the transplant:_____

Section **C** | **Court Order Information** *If this does not apply, skip to Section D.*

Is there a Court Order Specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ Yes ☐ No

| _____

List the name(s) of the dependent(s) that this applies to.

| _____

If yes, who is the person(s) listed to maintain health coverage?

| _____ | _____

What is the relation to the child(ren)? | Who has custody of the child(ren) more than 50% of the time?

Section **D** | **Name(s) of Dependent(s)**

| _____ | _____ | _____ | _____ | _____

Name | Relationship | Date of Birth | Sex | Social Security Number (Optional)

| _____ | _____ | _____ | _____ | _____

Name | Relationship | Date of Birth | Sex | Social Security Number (Optional)

| _____ | _____ | _____ | _____ | _____

Name | Relationship | Date of Birth | Sex | Social Security Number (Optional)

_____

Policyholder Signature | Date