CONSOCIATE HEALTH

Coordination of Benefits

Policy Member (Please Print Name): _____

Policy ID #: _____

Claims pending for (which member of the family) _____

Dear Policy Member:
In order for us to process claims for you and your family correctly, we need additional information. Please take a few moments to answer the following questions and return this form to us.

1. Are you or any member of your family eligible for benefits under any other kind of group health plan, including union welfare plans, Medicare, or school insurance?

   ○ **Yes** ○ **No** If you mark NO, this will apply for each dependent.

2. If YES, please provide the following information:

   Type of Coverage (Check ALL that apply, and circle the specific health coverage type)

   Health _____ PPO Preferred Provider Organization
   HMO Health Maintenance Organization
   HSA Qualified High Deductible Health Savings Account
   Are you or your employer making contributions to the account? ○ **Yes** ○ **No**

   Dental _____ Vision_____ RX _____

   Policy Holder's Name: _____

   Policy Holder's Date of Birth: _____

   Family Members Covered: _____

   Is this an **Employer Health Plan** or **Individual Policy**? (Circle One)

   Name of Insurance Company: _____

   Address: _____

   Phone Number: _____

3. Effective date of policy: _____

4. Is there any other information you feel we should know regarding the other insurance?

_____

_____

The information above is true and accurate to the best of my knowledge.

Signature: _____Date: _____

If you have any questions please contact our customer care department.
Our office hours are Monday-Friday 8:00 a.m. – 5:00 p.m.
Thank you for your cooperation. Claims Department

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