CONSOCIATE HEALTH

# Coordination of Benefits (COB)

* YOUR RESPONSE IS REQUIRED *

In order for us to process claims correctly for you and your family, we are required to obtain information regarding other insurance for you and your dependents. Please take a few moments to answer the following questions and return this form to us via fax (217) 422-9224, email to eligibilityrt@consociate.com, or mail to the address below.

Employee's Name (please print): _____

Employee Identification Number or Social Security Number: : _____

Address: _____ Phone Number: _____

1. Do you, or any dependent covered under this plan, have coverage with another plan, including union welfare plans, Medicare, or school insurance? ◉ **Yes** ○ **No** (please choose one)

   If "yes," please provide the following information. If "no," please proceed to #7.

Type of coverage: (choose all that apply)

- ☐ **Employer Sponsored Policy** — Effective date of coverage: _____
- ☐ **Medicare** (circle all that apply) ☐ **Part A** ☐ **Part B** ☐ **Part D** — Effective date of coverage: _____
- ☐ **State Funded Policy** — Effective date of coverage: _____
- ☐ **Retiree Policy** — Effective date of coverage: _____
- ☐ **Individual Policy** — Effective date of coverage: _____
- ☐ **Medicaid** — Effective date of coverage: _____
- ☐ **Other** — Effective date of coverage: _____

2. Policy holder's Name & Relationship to the Insured: _____
   Policy holder's Date of Birth: _____
   Dependents covered by this policy: _____
   Type of Coverage: Medical _____ Dental _____ Vision _____ Rx _____
   Name of other insurance company: _____

3. Is there any other information you feel we should know about the other insurance?

   _____

4. **If you are a Divorcee -** Do you have custody of your children? If Not divorced proceed to #7 _____

5. **If no to #4,** is there a court decree stating who is required to carry Primary Coverage? _____

6. **If yes to #5,** who is required to carry the coverage and what is their relationship to the dependent covered by their policy? _____

7. Form completed by: _____ _____ _____
   Please Print Signature Date

If you have any questions, please contact our Customer Service Department at (800) 798-2422. Our hours are Monday through Friday, 8:00 a.m. – 5:00 p.m. (CST). Thank you for your prompt attention to this matter.