



Subscriber Name:
Subscriber Identification Number:

COORDINATION OF BENEFITS QUESTIONNAIRE

Instructions: Please fill out all applicable sections completely by filling in the applicable circle(s) within each section and print clearly in black or blue ink in order for us to quickly and accurately process your request.

Section 1 - Member Insurance Information

Are any family members that are covered under the policy above covered under any other group health insurance policy (currently or during the past 2 years)?
Options: Yes, Medicare Only, Medicaid, CHAMPUS/TRICARE, No
Navigation: Complete sections 2-7, Complete sections 3-5 and 7, Skip to section 7

Section 2 - Other Insurance Information

Indicate name of other insurance carrier (fill in only one)
(NOTE: If more than one other coverage, please provide the other carrier information from this section on an additional page.)
Options: Aetna / US Healthcare, Blue Shield of NENY, CDPHP, CIGNA, GHI, HIP, Horizon BC of NJ, MVP, Oxford, United Health Care
Other (Name of Carrier) grid
Customer Service Telephone Number: grid

Type of enrollment (fill in only one): Individual, Family, Employee & Spouse, Parent & Child(ren)
Type of coverage (fill in all that apply): Hospital, Medical, Prescription Drug, Dental, Vision, Mental Health / Substance Abuse
Effective dates of the other coverage: Effective Date (mmddyyyy), Termination Date (mmddyyyy) (if applicable)

Section 3 - Primary Contract Holder Information of Other Insurance

Last Name, First Name
Primary Contract Holder on the policy indicated in section 2: grid
Identification Number or Medicare ID number: (Include all letters and prefix) grid
Group Number: (If Available) grid

Relationship of this contract holder to the contract holder listed at the top of this form: Self, Spouse, Dependent, Ex-Spouse or Legally Separated Spouse, Other
If relationship is "SELF" or "SPOUSE", indicate employment status: Actively working with employer offering other coverage, Not Actively Working/Long Term Disability, Retired from employer providing other coverage
If retired, date of retirement: grid

Continued on next page

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Section 4 – Medicare Enrollee Information

Name of Beneficiary	Coverage Type	Effective Date (mmddyyyy)	Medicare Entitlement Reason		
	<input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> Part D		<input type="radio"/> Age <input type="radio"/> Disability	<input type="radio"/> Kidney Failure Date of 1 st treatment: ___/___/___	
	<input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> Part D		<input type="radio"/> Age <input type="radio"/> Disability	<input type="radio"/> Kidney Failure Date of 1 st treatment: ___/___/___	

Section 5 – Covered Persons

Complete the following information for all persons covered under the other policy – including the subscriber in section 3 (attach a separate sheet if additional space is needed)

	Name (first and last name)	Relationship to the subscriber in section 3 (i.e., self, spouse, child, step-child, custodial parent)	Date of Birth (mm/dd/yyyy)	Fill in if covered by Medicare
a)		SELF		<input type="radio"/>
b)				<input type="radio"/>
c)				<input type="radio"/>
d)				<input type="radio"/>

Section 6 – Dependent Children

(only to be completed if there are dependent children covered under the other policy and the parents are divorced or legally separated)

- If there is a legally binding agreement for health care expenses, who is responsible? Attach a copy of the Court Order
- Mother Father Joint Agreement Legal Guardian
- If there is no legally binding agreement, who has primary custody (custodial parent)?
- Mother Father Joint Custody Legal Guardian
- Which dependent children in section 5 above does this apply to?
- B C D All

Section 7 – Contract Holder Signature

Insurance Fraud Statement: I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature _____

Date Signed _____

Daytime Telephone Number: [] [] [] - [] [] [] - [] [] [] [] [] []

This Coordination of Benefits questionnaire may be completed via:

- **Internet** – logon to www.PLAN_SPECIFIC_SITE.com
- **US Mail** – return this form in the enclosed pre-addressed envelope
- **Telephone** – contact your Customer Service Center at the toll-free number listed on the back of your identification card during normal business hours.