

**Coordination of Benefits Questionnaire**

Employee Name: \_\_\_\_\_  
(Please Print)

**Section A: Basic Information**

- 1. Are you, your spouse and/or dependents covered under another health, dental, and/or vision plan?  
**Please Check One:** Yes  No
- 2. Is your spouse employed? Yes  No  Is your spouse eligible for other coverage through his/her employer? Yes  No   
Employer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Section B: Policy Information**

- 1. Name of Other Insurance Carrier: \_\_\_\_\_ Type of Plan: Group  Individual  Retiree  COBRA
- 2. Name of Policy Holder: \_\_\_\_\_ Date of Birth of Policy Holder: \_\_\_\_\_
- 3. Coverage Effective Date: \_\_\_\_\_ Coverage Termination Date: \_\_\_\_\_
- 4. Please list name of those covered under other plan \_\_\_\_\_ Medical  Dental  Vision   
\_\_\_\_\_ Medical  Dental  Vision   
\_\_\_\_\_ Medical  Dental  Vision   
\_\_\_\_\_ Medical  Dental  Vision

**Section C: Dependent Child(ren) Information**

- 1. Are you or your spouse legally divorced or separated from the parent of any dependent child(ren) on this policy? Yes  No
- 2. Does one parent/guardian have full custody of the child(ren)? Yes  No   
If "Yes", which parent/guardian? \_\_\_\_\_ Which child(ren)? \_\_\_\_\_
- 3. Is one parent required by a court decree to provide health insurance coverage for the child(ren)? Yes  No   
If "Yes", which parent/guardian? \_\_\_\_\_ Which child(ren)? \_\_\_\_\_  
**\*If other coverage is in place due to a court order please include the court ordered policy information in Section B above.**
- 4. Please provide any court documentation supporting your response to the above questions. If this is a divorce situation, a court decree is required for the processing of claims.

**Section D: Medicare**

- | 1. Policy Holder's Name | Medicare Coverage (Check all that apply)   | Reason for eligibility under Medicare (Check all that apply)   |
|-------------------------|--|--|
| _____                   | A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> | Age (65 or Over) <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal <input type="checkbox"/> |
| _____                   | A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> | Age (65 or Over) <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal <input type="checkbox"/> |
2. Please attach a copy of your Medicare card and if you checked Disability and/or End Stage Renal, please attach a copy of the documents from Medicare.

**Section E: Signature**

- 1. I herby certify that the above statements are true and correct to the best of my knowledge.

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Employee Signature \_\_\_\_\_ Home and/or Work Phone # \_\_\_\_\_ Date \_\_\_\_\_

