Coordination of Benefits (COB) Subscriber Questionnaire

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It is important that you complete and return this survey. COB is a way to coordinate benefit payments when you or your dependents are covered by more than one health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

Are you, your spouse or any of your dependents covered by your primary plan also covered by any other group health Plan or Medicare?

☐ Yes ☐ No

If yes: — For other group health insurance plans, please complete sections 1 & 2.
— For Medicare coverage only, please complete sections 1 & 3.
— For other group heath and Medicare, complete sections 1, 2 & 3.

If no: — Please complete section 1 and sign your name.

PLEASE PRINT

SECTION 1—TO BE COMPLETED BY PRIMARY PLAN SUSCRIBER

Subscriber's Name	Birthdate	Employment Status ☐ Active ☐ Retired	Date of Retirement (If Applicable)
Member Number	Social Security Number	Phone Number / E-mail	
Mailing Address			

I certify that the information furnished by me on this form is true and correct at this time, and agree to inform you of any changes.

Subscriber's Signature — Today's Date

SECTION 2—OTHER COVERAGE INFORMATION

Name of Policyholder	Sex ☐ M ☐ F	Birthdate	Social Security Number	Relationship to You
Name of Other Health Plan			Policyholder Identification Number	
Other Health Plan's Address			Phone Number	
Employment Status ☐ Active ☐ Retired	Employer's Name		Date of Retirement (If Applicable)	

Type of Coverage	☐ Medical	☐ Drug	☐ Dental	☐ Vision
Effective Date	______	______	______	______
Cancellation Date	______	______	______	______

Please list any other dependents covered by this other plan. If there are more than four, please check this box ☐ and list the rest on the back of this form.

1. Name (First and Last)	Relationship to You	3. Name (First and Last)	Relationship to You
2. Name (First and Last)	Relationship to You	4. Name (First and Last)	Relationship to You

SECTION 3—MEDICARE COVERAGE INFORMATION

Name of Medicare Beneficiary		Social Security Number
Medicare Number ______	**Type of Coverage** Part A (Hospital) Effective Date ______ Part B (Medical) Effective Date ______ Part D (Drug) Effective Date ______	**Medicare Eligibility Due to:** ☐ Age ☐ Disability ☐ End-Stage Renal Disease Initial Dialysis Date: ______
Name of Medicare Beneficiary		Social Security Number
Medicare Number ______	**Type of Coverage** Part A (Hospital) Effective Date ______ Part B (Medical) Effective Date ______ Part D (Drug) Effective Date ______	**Medicare Eligibility Due to:** ☐ Age ☐ Disability ☐ End-Stage Renal Disease Initial Dialysis Date: ______