

Health Insurance Coordination of Benefits Form

Please complete this form as soon as possible. Any delay in completing this form may cause a denial of claims payment until the information is received.

Subscriber and Dependent Information				
Employee Name	Date of Birth	Social Security Number	Employer Use only: Group ID#	
			<input type="checkbox"/> Kaiser: 3246 <input type="checkbox"/> Cigna: 3345347 <input type="checkbox"/> Moda Dental: 10000159 <input type="checkbox"/> Willamette Dental: OR206	
Do you have other health insurance coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what other coverage do you have? <input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Do your dependents covered on the City of Salem health plan have other health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, what is the reason for no other coverage? <input type="checkbox"/> No other coverage available <input type="checkbox"/> Waived other coverage <input type="checkbox"/> Waiting period. Eligible on _____ If YES, list dependents who have other coverage below.		
Other Coverage	Relationship	Dependent Name	Are biological parents divorced or legally separated?	
<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Dental	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		N/A	
<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Dental	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete next section.	
<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Dental	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete next section.	
<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Dental	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Partner's Child		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete next section.	
Information Required for Children of Divorced or Legally Separated Biological Parents				
Biological Parent Name	Date of Birth	Provides health benefits?	Primary residence?	Address
Biological Mother:		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Biological Father:		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Decree stipulates joint custody <input type="checkbox"/> Decree stipulates other parent must provide health benefits <input type="checkbox"/> Decree does not stipulate any special provisions. <input type="checkbox"/> Other, please explain:				
A copy of the section of the court decree pertaining to health coverage or other documents may be requested.				
Other Coverage				
Medical / Prescription	Vision	Dental		
Subscriber Name:	Subscriber Name:	Subscriber Name:		
Subscriber Date of Birth:	Subscriber Date of Birth:	Subscriber Date of Birth:		
Subscriber Relationship to Employee:	Subscriber Relationship to Employee:	Subscriber Relationship to Employee:		
Insurance Carrier:	Insurance Carrier:	Insurance Carrier:		
Carrier Address:	Carrier Address:	Carrier Address:		
Carrier Phone:	Carrier Phone:	Carrier Phone:		
Group #:	Group #:	Group #:		
Subscriber ID#	Subscriber ID#	Subscriber ID#		
Effective Date:	Effective Date:	Effective Date:		
Coverage End Date:	Coverage End Date:	Coverage End Date:		
Policy Type: <input type="checkbox"/> Group-Employer <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B	Coverage Type: <input type="checkbox"/> Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Other	Policy Type: <input type="checkbox"/> Group-Employer <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B	Coverage Type: <input type="checkbox"/> Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Other	
Subscriber Acknowledgement and Signature				
I hereby certify that the information and statements that contained in this form are complete and accurate to the best of my knowledge. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information may be guilty of a criminal act punishable under law.				
Employee Signature: _____			Date: _____	
Employer Use Only				
<input type="checkbox"/> Submitted to Insurance/TPA Date: _____ HR Representative: _____ Employee# _____ <input type="checkbox"/> Tracking List (New hire only)				