



**COORDINATION OF BENEFITS INFORMATION FORM**

RE: Member#:

Member Name:

<b>SECTION III: DEPENDENT INFORMATION</b>		
Please complete the following information for any dependent covered by your policy by court order. If there is a court order or divorce decree we will need a copy of the following: the first page showing the respondent and petitioner, sections regarding health insurance, and the page with the court official signature and date signed.		
Name of dependent: (First & Last Name)	Who has physical custody?	Who is responsible for coverage?
1.		
2.		
3.		

<b>SECTION IV: OTHER HEALTH INSURANCE</b>				
Please enclose a copy of the front and back of your other active insurance card.				
Name of policyholder:	Date of Birth (mo/day/yr)	Policy Number:	Effective Date:	Term Date:
Please list below the contract holder and any other dependent covered by other health/medical policy: (use additional paper if needed)				
Name: Dependent Name	Date of Birth DOB	Relationship	Effective Date:	Term Date:
If Employer provided coverage please provide Employer's name, address, and phone number with area code:				
Insurance Company providing other coverage. Name, address, phone number with area code:				
Policy #	Member ID#	Coverage start date:		
Coverages (mark all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> VA Benefits				
<input type="checkbox"/> Continuation <input type="checkbox"/> Retirement <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____				

<b>Section V: MEDICARE - Please enclose a copy of the front and back of your Medicare card</b>				
Is any member of your policy eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the card holder of Cox HealthPlans policy actively employed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please provide the following information: (please use additional paper if necessary)				
Name:	Part A?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:	Reason for Medicare eligibility: <input type="checkbox"/> Disability
Medicare:	Part B?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal Disease
Name:	Part A?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:	Reason for Medicare eligibility: <input type="checkbox"/> Disability
Medicare:	Part B?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal Disease
Name:	Part A?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date:	Reason for Medicare eligibility: <input type="checkbox"/> Disability
Medicare:	Part B?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal Disease

**I certify that the statements contained in this document are true and correct to the best of my knowledge.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Thank you for your cooperation. It is a privilege to provide your health care coverage.