2017 Coordination of Benefits

Claim Number:

We are in receipt of the above referenced claim. The Plan in which you and your dependent(s) are covered contains a Coordination of Benefits provision that makes it necessary for us to periodically request new and/or updated information as it relates to the possibility of other insurance coverage. Please answer the following questions and return this form to us as quickly as possible to prevent further delay in the processing of your claim and ensure proper benefit payment.

Participant Information		
Participant's Full Name (Last, First, M.I.):		**Date of Birth** (mm/dd/yyyy):
BCBS ID#:	**OR Social Security #:**	
Gender: ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated	
Street Address		
City:	**State:**	**Zip Code:**
Home Phone #:	**Cell Phone #:**	
Email Address:		

If your spouse is to be covered on the Plan, you must provide their social security number for Medicare Reporting purposes.

Spouse Information	
Spouse Name (Last, First, M.I.):	**Date of Birth** (mm/dd/yyyy):
Gender: ☐ Male ☐ Female	**Social Security #:**
Does your spouse have other insurance/coverage? ☐ Yes ☐ No	
If yes, please complete ALL of the following:	
Spouse's Employer:	
Spouse's Insurance Co.:	**Policy#:**
Spouse's Effective Date of Other Insurance Coverage:	

Dependent Information – Please list all other enrolled dependents below				
Relationship	**Name** (Last, First, M.I.)	**Date of Birth** (mm/dd/yyyy)	**Gender**	**Social Security #**
Child			☐ Male ☐ Female	
Child			☐ Male ☐ Female	
Child			☐ Male ☐ Female	
Child			☐ Male ☐ Female	
Child			☐ Male ☐ Female	
Do any of your dependent children have other insurance/coverage? ☐ Yes ☐ No				

If yes, please complete ALL of the following:	
Dependent's Name:	
Dependent's Employer:	
Dependent's Insurance Co.:	**Policy #:**
Dependent's Effective Date of Other Insurance Coverage:	

Medicare Information		
Are you and/or your dependents Medicare eligible? ☐ Yes ☐ No		
If yes, pleas list who is eligible and the reason:		
Name	**Reason**	
	☐ Age 65+ ☐ Disabled under age 65 ☐ End Stage Renal Disease or Disabled ESRD	
	☐ Age 65+ ☐ Disabled under age 65 ☐ End Stage Renal Disease or Disabled ESRD	
	☐ Age 65+ ☐ Disabled under age 65 ☐ End Stage Renal Disease or Disabled ESRD	
Effective Date For:		
Medicare Part A:	**Medicare Part B:**	**Medicare Part D:**

Financial Responsibility Information
Do you have a dependent child covered under this plan and someone else has financial responsibility? ☐ Yes ☐ No
If yes, indicate who and under what circumstances:
If yes, please send us a copy of the page(s) from the legal document (court decree, divorce decree, etc.) that validates this requirement.

Certification

I certify that these statements and answers are true to the best of my knowledge and belief.
Please sign and return.

Participant's Signature: _____ **Date:** _____

Print Name: _____

Thank you for helping us serve you better. Please return this completed form by mail or fax to:

Professional Benefit Administrators, Inc.
900 Jorie Blvd, Suite 250
Oak Brook, IL 60523
Fax: (630) 286-4678