2026 Coordination of Benefits

Date: _____
Employee Name: _____
Address: _____
Dependent Name(s): _____
BCBS ID Number: _____
Email Address: _____
Phone Number: _____

The Group Health Insurance Plan in which you and your dependent(s) are covered contains a Coordination of Benefits ("COB") provision that **requires other insurance information be provided once a year. Failure to do so will result in claims being denied for payment until received.**

If you are single and do not have any dependents (spouse or children) covered under this Plan, you do not need to complete this form.

Please complete the below questionnaire and provide the information in one of the following methods.

- Mail to: Southwest Service Administrators
  PO Box 43110
- Phoenix, AZ 85080-3110
- Fax to: 602-249-3795
- Upload to **www.ssatpa.com** by clicking on "New Message"

Section 1: Spouse Info	
Is your spouse employed? ☐ Yes ☐ No ☐ Does not apply	
If yes, is your spouse eligible for coverage through his/her employer? ☐ Yes ☐ No	
If yes, did your spouse elect insurance coverage through his/her employer? ☐ Yes ☐ No	
If yes, please complete the following:	
Spouse ID#:	**Spouse Name:**
Spouse Date of Birth:	**Employer Name/Phone:**
Employer Address:	
Insurance Company Name:	
Insurance Company Phone#:	**Plan #:**
Is this an HMO policy? ☐ Yes ☐ No	
Coverage (Mark all that apply) ☐ Medical ☐ Single ☐ Family Effective Date _____ ☐ Dental ☐ Single ☐ Family Effective Date _____ ☐ Vision ☐ Single ☐ Family Effective Date _____ ☐ Rx ☐ Single ☐ Family Effective Date _____	

If your spouse no longer has coverage, please provide the termination date (*please forward a copy of the creditable coverage letter/termination letter verifying date the coverage terminated*).

Please list all family members covered under the other insurance coverage. If more than one insurance carrier exists, list the name, address, phone number and group/plan number of the other insurance carrier(s):

Section 2: Medicare

Are you and/or your dependents Medicare eligible? ☐ Yes ☐ No

If yes, please list who is eligible and the reason (Age 65 or older, Disabled under age 65, End Stage Renal Disease or Disabled ESRD):

Effective Date For: Medicare Part A _____ Medicare Part B _____ Medicare Part D _____

Section 3: Financial Responsibility *(Complete only if you are a parent/stepparent of a child who is listed on a divorce decree or court order)*

Do you have a dependent child under this plan and someone else has financial responsibility?
☐ Yes ☐ No

If yes, *please send us a copy of the page(s) from the legal document (court decree, divorce decree, etc.) that validates this requirement*. If you have already submitted these legal documents, you may disregard this request.

If no, please check the following statements as they apply to your situation:

- ☐ The responsible party does not currently provide insurance coverage for the dependent(s).
- ☐ The responsible party cannot be located.
- ☐ There is no court order or divorce decree on file.
- ☐ Father/Mother deceased.

If there is no court order or divorce decree:
Please provide other biological parent's name and date of birth.

Does the other biological parent have other insurance through an employer? ☐ Yes ☐ No

Are the biological parents living together? ☐ Yes ☐ No

If the biological parents are not living together, who has primary physical custody of the child?

Section 4: Adult Dependent Child	
Do you have a dependent child over the age of 19 (Adult Dependent Child) who is enrolled for other coverage *through their employer sponsored group health plan* or *their spouse's employer sponsored group health plan*? ☐ Yes ☐ No	
If yes, please indicate which child:	
Insurance Company Name:	
Insurance Company Phone #:	**Plan #:**
If yes, please indicate which child:	
Insurance Company Name:	
Insurance Company Phone #:	**Plan #:**
If yes, please indicate which child:	
Insurance Company Name:	
Insurance Company Phone #:	**Plan #:**

Certification

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

Participant Signature: _____ Date: _____

Print Name: _____

Sincerely,

Automobile Mechanics' Local #701 Welfare Fund