SWSCHP
State-Wide Schools Cooperative Health Plan

Instructions for Completing the Coordination of Benefits Questionnaire

The coordination of benefits (COB) questionnaire on page two of this document contains questions about other forms of insurance you may have. Having up-to-date COB information enables your employer's benefit plan to save money by avoiding duplicate payments or overpayment.

In order to update your Coordination of Benefits information, please respond to the questions in this letter, and return the questionnaire to SWSCHP within 10 days. Even if you do not have another form of insurance, please complete and sign the form. **Failure to respond will result in a delay in processing your claims**.

Please complete and sign the COB Questionnaire and mail it to:

SWSCHP
12 Metro Park Road
Second Floor
Colonie, NY 12205-1139

Alternatively, you may fax the form to (518) 437-1182 once completed, or you may upload it to the online enrollment system at capben.com

Instructions

Please read the following and complete **only** the sections of the form that apply to you and any enrolled dependents.

- If you and any enrolled dependents have NO other health insurance coverage, please check #1 on the *COB Questionnaire* (page 2) and complete Section C with your signature.
- If you or any enrolled dependents have other health insurance coverage, please check #2 on the *COB Questionnaire* (page 2), and complete Sections A and then section C with your signature.
- If you or any enrolled dependents have Medicare coverage, please check #3 on the COB Questionnaire (page 2) and complete Section B and then Section C with your signature.

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Coordination of Benefits Questionnaire

SWSCHP Subscriber Name_____

1. _____I (and/or my dependents) have NO other health coverage. **(If you check this, go to Section C).**
2. _____I (and/or my dependents) have other health coverage. **(If you check this, complete Sections A and C).**
3. _____I (and/or my dependents) have **Medicare** health coverage. **(If you check this, complete Sections B and C).**

SECTION A: If you checked #2 above, you must fill out this section. (Please circle if a choice is indicated).				
Name of Subscriber of Other Insurance:				
Employment Status of other insurance subscriber:	Active	Retired	Retirement Date	
Other coverage effective date	Other coverage term date			
Do you or family members have any other prescription drug plans?		No	Yes	
Please list family member(s) who are insured:				
Other Insurance Company name:				
Other Insurance Company address:				
Other Insurance Company phone number:				
ID# of other policy:				
Group # of other policy:				
Other plan type:	Individual	Family	Husband/Wife	Parent/Child
Other benefit coverage:	Medical	Hospital		
Employment Status of SWSCHP subscriber:	Active	Retired	Retirement Date	
SECTION B: If you checked #3 above, you must fill out this section. (Please circle if a choice is indicated).				
Family member(s) insured with Medicare:				
Medicare #(s):				
Effective Date of Part A Medicare:				
Effective Date of Part B Medicare:				
Employment Status of Medicare subscriber:	Active	Retired	Retirement Date	
Employment Status of SWSCHP subscriber:	Active	Retired	Retirement Date	
Insured is eligible for Medicare benefits because?	Age (65)	Disability	End Stage Renal Disease (ESRD)	
If you indicated ESRD, is individual on dialysis?	No	Yes	Date Dialysis Began	
If you indicated YES, where is dialysis administered?	Home	Hospital		
Did individual receive a transplant?	No	Yes	Date	
SECTION C: Please PRINT your name, sign, and date below.				
The Coordination of Benefits (COB) provision is part of your group health insurance plan. You agree to abide by the COB provision through enrollment in your group health insurance plan. Any person who knowingly and with intent to defraud any insurance company by filing a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime.				
PRINT NAME				
SIGNATURE				
DATE				