



## 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