COORDINATION OF BENEFITS

QUESTIONNAIRE

Do you or a member of your family currently have healthcare coverage with another plan?

____ **Yes** (Please complete the form below and sign include your policy ID number and return to your Benefits Department)

____ **No** (Please sign and include your policy ID number and return to your Benefits Department)

Medicare Information (If Medicare covers you or a member of your family, please complete this section)

The following information can be found on your health insurance identification card from Medicare.

Cardholder Name	Medicare ID#	Effective Dates	Rx Date	Medicare Entitlement Reason (circle one)
		Part A: / / Part B: / /	/ /	Age Disability ALS ESRD
		Part A: / / Part B: / /	/ /	Age Disability ALS ESRD
		Part A: / / Part B: / /	/ /	Age Disability ALS ESRD
		Part A: / / Part B: / /	/ /	Age Disability ALS ESRD

Other Insurance Carrier Information (Space for more than one carrier is provided)

Policyholder Name ❶:	Policyholder Name ❷:
Date of Birth: / /	Date of Birth: / /
Status: ☐ Active ☐ Retired ☐ COBRA	Status: ☐ Active ☐ Retired ☐ COBRA
Other Policy Covers: ☐ Hospital ☐ Medical ☐ Dental ☐ Vision ☐ Drug	Other Policy Covers: ☐ Hospital ☐ Medical ☐ Dental ☐ Vision ☐ Drug
Group Number:	Group Number:
Policyholder Number:	Policyholder Number:
Effective Date:	Effective Date:
Cancellation Date:	Cancellation Date:
Name of Insurance Company:	Name of Insurance Company:
City, State, ZIP:	City, State, ZIP:
Phone Number:	Phone Number:

If other insurance is family coverage, please list names, birth dates and relationship of those covered under this policy. If there is a court order designating responsibility for a child's healthcare, please attach a completed copy of the document with this response.

Please indicate whether the other insurance is ☐ Single or ☐ Family.

Last Name	First	MI	Birth Date	Relationship	Policy (1 or 2)

I certify the above information is correct and complete to the best of my knowledge:

MMO Policy # ____________________

Name (printed) ____________________ Signature ____________________ Date ____________________

Warning: Any person who, with intent to defrauding or knowing that he is fraud against an insurer, submits an application or files a claim containing a false or deceptive is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Group # ______________ Section ________