

# Coordination of Benefits

Policy Member (Please Print Name): \_\_\_\_\_

Policy ID #: \_\_\_\_\_

Claims pending for (which member of the family) \_\_\_\_\_

Dear Policy Member:

In order for us to process claims for you and your family correctly, we need additional information. Please take a few moments to answer the following questions and return this form to us.

1. Are you or any member of your family eligible for benefits under any other kind of group health plan, including union welfare plans, Medicare, or school insurance?

Yes       No    If you mark NO, this will apply for each dependent.

2. If YES, please provide the following information:

Type of Coverage (Circle ALL that Apply)

Health \_\_\_\_\_ PPO Preferred Provider Organization  
HMO Health Maintenance Organization  
H.S.A. Qualified High Deductible Health Savings Account  
Are you or your employer making contributions to the account? Yes \_\_\_\_\_ No \_\_\_\_\_

Dental \_\_\_\_\_ Vision \_\_\_\_\_ RX \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Family Members Covered: \_\_\_\_\_

Is this an **Employer Health Plan** or **Individual Policy**? (Circle One)

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

3. Effective date of policy: \_\_\_\_\_

4. Is there any other information you feel we should know regarding the other insurance?

\_\_\_\_\_  
\_\_\_\_\_

The information above is true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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If you have any questions please contact our customer service department. Our office hours are Monday-Friday 8:00 a.m. -5:00 p.m. Thank you for your cooperation. Claims Department

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