



COORDINATION OF BENEFITS (COB) FORM

Reason for this form: This form is to be used to verify that a patient does not have coverage other than their group health plan administered by Planned Administrators, Inc.

Employee Name: _____

Address: _____

UMID: _____ Group: _____ Location: _____

Table with 3 columns: Does Participant have other coverage?, Yes, No. Multiple rows for data entry.

Your group health plan contains a coordination of benefits (COB) provision to ensure correct benefits are provided on claims for members covered by more than one health plan. We need information about possible other insurance coverage, including Medicare, before we can process your claim.

Do you or does any member of your family have other group health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare? YES _____ NO _____

If you checked "NO," please skip to the bottom of this form and sign and date.

If you checked "YES," please complete the following information:

If YES: MEDICARE Effective Date _____ Health Insurance Claim Number (HICN) _____

Family Member's Name _____ and Social Security # _____

Name of other insurance _____ Policy # _____

Address of other insurance _____

Effective date of other coverage _____

Dependents covered under this policy _____

What does this policy cover? (please check) MEDICAL DENTAL VISION DRUG

Name of policyholder _____

Date of birth of policyholder _____

Employee's Signature _____ Date _____

Please sign, date and return this letter to: Planned Administrators, Inc. P.O. Box 6927 Columbia, SC 29260