



COORDINATION OF BENEFITS INFORMATION

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. **NOTE: CLAIMS WILL BE DENIED UNTIL THIS DATA IS RECEIVED BY PAI.**

Employee Name: _____

Address: _____

UMID: _____ Group: _____ Location: _____

Name(s) of Dependent(s) on PAI Policy

	<u>Name (First and Last)</u>	<u>Relationship to You</u>	<u>Social Security #</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Please list any Dependent(s), AGE 19 AND OVER, who are eligible for their own employer sponsored medical health insurance.

	<u>Name (First and Last)</u>	<u>Relationship to You</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____

Do you or does any member of your family have other group health, dental or drug coverage, Federal Employees' Program (FEP), or Medicare?
 No If No, please skip to the bottom of this form, sign, date and return this form to us.
 Yes If Yes, please complete entire form, sign, and return.

SECTION 1 OTHER HEALTH COVERAGE INFORMATION (Excluding Medicare – See Section 2)

Please provide information about policy holder of the other health coverage. Attach additional pages if needed.

Name of policy holder of other coverage	Relationship to you	Social Security #	Employer	Birth date
Insurance company name	Insurance company address		Phone #	
Member ID / Policy #		Group #	Effective Date	

Type of coverage: Single Family Type of Plan: Medical Dental Vision Prescription Drug

Who is covered by this other plan? Include yourself if applicable.

	<u>Name (First and Last)</u>	<u>Relationship to You</u>	<u>Social Security #</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

SECTION 2 MEDICARE COVERAGE

Are you or any member of your family covered by Medicare? Yes No

If YES, name of person with Medicare _____ Social Security # _____

Medicare Effective Date: _____ Health Insurance Claim Number (HICN) _____

Employee's Signature **Date**

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