COORDINATION OF BENEFITS FORM

Member Name: _____**Member ID#**: _____

Do you or your dependents have **other** health insurance? __YES __NO
Do you or your dependents have Medicare? __YES __NO

If you answered "NO" to both questions listed above, please sign this form & return to PIBF.

ADDITIONAL INSURANCE:

Policy Holder's Name: _____ DOB:_____

Policy Holder's Address: _____

Policy ID Number_____ Group#_____

Effective Date_____ Term Date_____

Coverage type: ___ active employment ___ retirement ___ private policy ___ Medicare
___ Medicare Supplement ___ Medicaid

Coverage plan is: ____ Single ____ Family

List all dependents that are covered by this policy:_____

_____

If retirement coverage, please list date of retirement ____/____/_____

Does plan provide: Prescription ____ Medical ____ Dental ____ Vision ____

Employer Name and Address_____
city _____ state _____ zip _____

Other Carrier's Name and Address _____
city _____ state _____ zip _____

Telephone # (____) ___-_____

IF YOU HAVE ADDITIONAL INSURANCE,
PLEASE PROVIDE A FRONT AND BACK COPY OF YOUR INSURANCE CARD

IF PRIMARY INSURANCE HAS TERMED, PLEASE PROVIDE LETTER OF CREDIBLE COVERAGE FROM INSURANCE COMPANY SHOWING EFFECTIVE / TERM DATES.

The undersigned certifies that to the best of their knowledge, the facts set forth are true and correct. I HEREBY AUTHORIZE my insurance company or other provider to release any medical or other information necessary. Any fraudulent information could result in legal action.

Signature of Member_____**Date** _____/____/_____

Failure to make a complete disclosure of other insurance coverage will result in a delay of payment of your claims. Any resulting overpayment by our office must be reimbursed.