

## 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.