# Request for other coverage information

For your claims to be processed timely, this Coordination of Benefits (COB) form is required **if you or dependents on your policy** have coverage through another medical health insurance plan.

If you have any questions, please call 800-843-1329, Monday - Friday, between 8 a.m. and 5 p.m.

| **Policyholder name** | **Policy number** |
|---|---|
| | |

**Marital status**

☐ Never married ☐ Married ☐ Single ☐ Domestic partner ☐ Separated ☐ Divorced

## Section A - Other medical health insurance

Please complete this section if you, your spouse, or dependents have coverage other than this plan. (Use additional paper if necessary.)

| **First name** | **Last name** | **Relationship** | **Effective date** (mm/dd/yyyy) | **Termination date** (mm/dd/yyyy) | **Reside in same household?** |
|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

| **Insurance carrier name** | **Phone number** |
|---|---|
| | |

| **Insurance carrier address** | **City** | **State** | **ZIP** |
|---|---|---|---|
| | | | |

| **Policyholder name** | **Policyholder ID** | **Date of birth** (mm/dd/yyyy) |
|---|---|---|
| | | |

| **Policyholder address** | **City** | **State** | **ZIP** |
|---|---|---|---|
| | | | |

## Section B - Dependent children of separated/divorced parents

Please complete this section for any dependent child(ren) listed in Section A whose parents are divorced, legally separated, or who have some other legal reason for providing coverage. (Use additional paper if necessary.)

| **Dependent first name** | **Dependent last name** | **Relationship** | **Other Insurance Carrier** | **Policy ID** | **Effective date** (mm/dd/yyyy) | **Termination date** (mm/dd/yyyy) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Section B - Dependent children of separated/divorced parents (continued)

**Other insurance policyholder name**

**Date of birth** (mm/dd/yyyy)

**Other insurance responsible due to**

☐ Custody ☐ Divorce decree ☐ Child support order

***If any of these boxes are checked, please enclose a copy of the complete document that establishes financial responsibility for medical care.***

## Section C - Medicare

Please complete this section if you or someone on your policy also has Medicare.

| First name | Last name | Medicare # | | Begin date (mm/dd/yyyy) | End date (mm/dd/yyyy) |
|---|---|---|---|---|---|
| | | | Part A | | |
| | | | Part B | | |
| | | | Reason | ☐ 65+ ☐ Disability ☐ ESRD | |
| | | | Part A | | |
| | | | Part B | | |
| | | | Reason | ☐ 65+ ☐ Disability ☐ ESRD | |
| | | | Part A | | |
| | | | Part B | | |
| | | | Reason | ☐ 65+ ☐ Disability ☐ ESRD | |

## Section D - Signature

☐ I certify that the information provided on this form is true, complete and correct.

**Signature**

**Date** (mm/dd/yyyy)

**Please return completed and signed form to:**

Health Advantage
ATTN: COB Department
P.O. Box 2181
Little Rock, AR 72203-9974