CONSOCIATE
benefits at work

P. O. Box 1068, Decatur Illinois 62525-1068 • Telephone (800) 798-2422 • Fax (217) 422-9224

Coordination of Benefits

Employee's Name (Please print):_____

Employee's Consociate ID# or Social Security #:_____

Dear Member:
In order for us to process claims correctly for you and your covered family members, if any, we are required to obtain information regarding other insurance that you/they might have. Please take a few moments to answer the following questions and return the form to us at the address or fax above. If additional space is needed, please either copy this page to input additional information or provide information on another sheet of paper.

1. Are you or any of your dependents covered under this plan, eligible for benefits under any other kind of group health plan, including union welfare plans, Medicare or school insurance?

MEDICAL

_____ Yes, Self _____ Yes, Spouse _____ Yes, Child 1 _____ Yes, Child 2 _____ Yes, Child 3

If other coverage, list Name of Child: 1_____ 2_____ 3_____

_____ No, Self _____ No, Spouse _____ No, Child 1 _____ No, Child 2 _____ No, Child 3

DENTAL/VISION

_____ Yes, Self _____ Yes, Spouse _____ Yes, Child 1 _____ Yes, Child 2 _____ Yes, Child 3

If other coverage, list Name of Child: 1_____ 2_____ 3_____

_____ No, Self _____ No, Spouse _____ No, Child 1 _____ No, Child 2 _____ No, Child 3

2. If yes to anyone in item #1 above, please provide information on the type of other insurance coverage:

Self, Spouse, Child #	Employer Sponsored Plan (List employer name, policy # and effective date)	State Funded Policy (List policy name, # and effective date)	Medicare (List whether member has Plan A or Plan B, or both, and effective date)	Retiree Policy (List employer name, policy # and effective date)	Individual Policy (List policy name and # and effective date)
a.					
b.					
c.					
d.					
e.					

A. Please list name, relationship and date of birth (DOB) of the policyholder who carries other coverage:

a.) Policyholder name _____ Relationship to person listed _____Policyholder DOB _____

b.) Policyholder name _____ Relationship to person listed _____Policyholder DOB _____

c.) Policyholder name _____ Relationship to person listed _____Policyholder DOB _____

d.) Policyholder name _____ Relationship to person listed _____Policyholder DOB _____

e.) Policyholder name _____ Relationship to person listed _____Policyholder DOB _____

B. Are you or any dependent covered under this Plan disabled? _____ Yes _____ No. If yes, Please state name of the disabled family member here: _____

3. If you cover children under this Plan and if you are divorced, is there a court decree regarding health coverage? If so, who is required to carry primary coverage on your dependents? (Please state child's name and what coverage should be primary.)

_____

4. Form completed by: _____/_____/_____

Please Print Signature Date

If you have any questions, please contact our Customer Care Department at (800) 798-2422. Our normal business hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. (CST). Coordination of Benefits must be submitted in writing.