



COORDINATION OF BENEFITS (COB) FORM

Reason for this form: This form is to be used to verify that a patient does not have coverage other than their group health plan administered by Planned Administrators, Inc.

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Group Name: \_\_\_\_\_

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.

Are you or any members of your family covered by any other insurance program or Medicare?

YES \_\_\_\_\_ NO \_\_\_\_\_

If you checked "NO," please skip to the bottom of this form and sign and date.

If you checked "YES," please complete the following information:

Name of other insurance \_\_\_\_\_

Address of other insurance \_\_\_\_\_

Effective date of other coverage \_\_\_\_\_

Dependents covered under this policy \_\_\_\_\_

What does this policy cover? (please circle) MEDICAL DENTAL VISION DRUG

Name of policy holder \_\_\_\_\_

Date of birth of policyholder \_\_\_\_\_

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_

(Please sign, date and return this letter to Planned Administrators, Inc., P.O. Box 6927, Columbia, SC 29260)