



Affordable Benefit Administrators, Inc.

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www.benefitsaba.com

OTHER INSURANCE COVERAGE QUESTIONNAIRE

Your health plan contains a Coordination of Benefits (COB) provision. To ensure that correct benefits are paid on claims for members covered by more than one insurance plan, we need you to complete, sign, date and return this form.

Your name and address

Name of Employer

ID Nbr.: _____

Date: _____

1. Do you or any dependents have any other group Medical, Dental or Medicare coverage? No Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM BY MAIL OR FAX 1(818) 842-0225.

IF YES, PLEASE COMPLETE THE INFORMATION BELOW.

2. Please list the family members covered by the other policy and the type of coverage you have:

_____ Medical Dental Medicare

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For additional family members, attach a separate sheet with the information.

3. Name of other Policyholder: _____ Date of Birth: _____

Relationship to you: _____

Name of Employer (if covered thru group plan): _____

Name of other Insurance Company: _____

Policy Nbr.: _____ ID Nbr.: _____

Effective Date: _____ Termination Date: _____

4. If there is a divorce or separation, please name the person responsible for the health care expenses:

If there is a divorce decree, please send a copy to us.

If there is not a divorce / court decree, who has custody of the children? _____

5. Are you actively working?

Start Date: _____

Last day of active employment: _____

6. Are you or any family member covered by Medicare? No Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM BY MAIL OR FAX 1(818) 842-0225.

IF YES, PLEASE COMPLETE THE INFORMATION BELOW.

Name: _____ Date of Birth: _____

Medicare Nbr: _____

Part A Effective Date: _____ Part B Effective Date: _____

Reason for Medicare: Age Disability ESRD (Date of First Dialysis: _____)

Your Signature: _____

Date: _____
