



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: _____

Policy ID Number _____ Group# _____

Effective Date _____ Term Date _____

Coverage type: active employment retirement private policy Medicare 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 # (____) ____ - _____

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.