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

☐ Medicare Supplement ☐ 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 # (____) ___-_____

IF PRIMARY INSURANCE HAS TERMED, PLEASE PROVIDE LETTER OF CREDIBLE COVERAGE FROM INSURANCE COMPANY SHOWING EFFECTIVE / TERM DATES.

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.