COORDINATION OF BENEFITS FORM
FOR DEPENDENT YOUNG ADULTS AGE 19-26

PIBF Member Name: ______________________________ **PIBF Member ID #:**______________________________

Dependents Name: ____

Do you have **other*** health insurance? YES NO
Do you have Medicare? YES NO

(*other insurance would include coverage under any other plan or the plan of either parent)

If you answered "NO" to both questions listed above, please sign & return to PIBF.

Signature of Dependent Young Adult: ____ Date: ________________

If you answered "YES" to either question, please have the policy holder complete the additional Insurance section.

ADDITIONAL INFORMATION ON OTHER HEALTH INSURANCE:

Policy Holder's Name: ____

Policy ID Number: ____ Group # ____________________________

Effective Date: ______________ Term Date: _____________ **Policy Holder's Birth 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.

Policy Holder's Signature: ____ 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.