Coordination of Benefits Form

CLEAR FORM

Member Name: _____ Member ID Number: _____ Today's date: _____

Coordination Of Benefits (COB)

Are you or any member of your family covered under any other Health Insurance or Medicare? ☐ Yes ☐ No

Policy Holder Name:	Social Security Number:	Telephone Number:
Insurance Company Name:	Policy Number:	Effective date:
Insurance Company address:	City: State: Zip code:	

Please check type of policy: ☐ Family ☐ Individual ☐ Medicare A ☐ Medicare B ☐ Medicare A & B

If group coverage, please give employer name and address:
Employer Name:

Employer address:	City: State: Zip code:

Other Party Liability (OPL)

Was another party, defective product or a motor vehicle accident responsible for your illness or injury? ☐ Yes ☐ No

Please state how you were injured and place of injury:

Injury date: _____

As a result of your illness or injury, do you intend to file a claim against some other party? ☐ Yes ☐ No

Name and address of other party:
Party Name:

Party address:	City: State: Zip code:

If your injury resulted from a motor vehicle accident, were you: ☐ Driver ☐ Passenger ☐ Pedestrian

Your automobile insurance company name and address:
Automobile Insurance Company Name:

Automobile Insurance Company address:	City: State: Zip code:

If you have retained an attorney, please give name and address:
Attorney Name:

Attorney address:	City: State: Zip code:

Workers' Compensation (WC)

Was this a work-related illness or injury? ☐ Yes ☐ No

Describe the nature of your illness:

Illness/Injury date: _____

Name and address of your employer:

Employer Name:

Employer address:	City:	State:	Zip code:

Name and address of Workmen's Compensation claim:

Workmen's Compensation Claim Name:

Workmen's Compensation Claim address:	City:	State:	Zip code:

Have you filed a Worker's Compensation claim? ☐ Yes ☐ No

Have you retained an attorney to protect your rights? ☐ Yes ☐ No

If yes, give name and address:

Attorney Name:

Attorney address:	City:	State:	Zip code:

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