TIMBERLAWN
MENTAL HEALTH SYSTEM℠

COORDINATION OF BENEFITS

This form must be completed and on file **BEFORE** we can process your claim; if we do not receive this information, you may be liable for payment to your provider.

* *

Subscriber Name ______________________ RE: Member Name ______________________

Address 1 ______________________ Member # ______________________

Address 2 ______________________ Carrier ______________________

City, State, Zip ______________________

COORDINATION OF BENEFITS (COB) FORM

SECTION I

1. Do you have other coverage through another group health plan? ❑ Yes ❑ No
2. If so, are you covered as an active employee or retiree? ❑ Active ❑ Retiree
3. Please indicate the name of the carrier and effective date: Carrier ____________ Effective Date ____________
4. If you are married, is your spouse employed? ❑ Yes ❑ No
5. If yes, name of spouse's employer ______________________ Spouse's date of birth ____________
6. Does you spouse have group coverage through his/her employer? ❑ Yes ❑ No
7. If yes, complete SECTION II.

SECTION II

1. Name of spouse's insurance carrier and phone number: Carrier ____________ Phone Number ____________
2. Group/Policy number ______________________ Insured ID/SSN ______________________
3. Effective Date ____________ Termination Date ____________
4. Coverage: Family ____________ Individual ____________

SECTION III

If you have children, and you are legally separated or divorced, please complete the following:

1. Is there a court decree stating financial responsibility? ❑ Yes ❑ No
2. Who has responsibility? ______________________
3. Who has custody of the children? ______________________
4. Does anyone other then the natural parents (step-parents) carry insurance on the dependent(s)? ❑ Yes ❑ No
5. If yes, name of policyholder ______________________ Insurance Carrier ____________
   ID/SSN ______________________ Phone Number ____________

SECTION IV

1. Are you, your spouse, or your dependents covered under Medicare? ❑ Yes ❑ No
   If yes, please complete the following:
2. Name and date of birth of person(s) covered? ______________________
3. Medicare ID # ____________
4. Is Medicare coverage due to disability caused by end stage renal disease? ❑ Yes ❑ No
5. Date of onset ____________
6. Date eligible for Medicare ____________
7. Do you have part A? ❑ Yes ❑ No
8. Do you have part B? ❑ Yes ❑ No

I certify that the above information is correct. **Employee Signature** ______________________

Date ____________

Form #3828 12/01