OHIO LABORERS Benefits

COORDINATION OF BENEFITS

Name:_____ SSN: XXX-XX-_____

Address:_____

Please complete the following questionnaire if you or your family currently have or has had other medical insurance within the past 12 months.

Do you or any member of your family have other health insurance?_____ YES _____NO

If yes, please continue. If no, please sign, date, and return this form in the envelope provided.

In whose name is the other policy:_____His/Her date of birth:____/____/____
MM DD YYYY

The other policy covers: _____Hospital _____Medical _____Dental _____Vision _____Drug

Policyholder status: _____Active _____Retired _____COBRA (Continuation of coverage)

Policy Type: _____Family _____Single Group Number:_____

Policy Number:_____ Effective Date:_____ Cancellation Date:_____

Name of Insurance Company:_____

Street Address:_____

City, State, Zip:_____ Telephone #:_____

If the other insurance is Family coverage, list the names, birth dates and relationships of those covered under this policy. If there is a court order designating responsibility for a child's health care, please attach a copy of that document to your response. *(Please attach additional sheets if more than three dependents.)*

Last Name	First	MI	Birthdate	Relationship

If Medicare covers you: Effective Date of Part A:_____ Part B:_____ Part D:_____

Is the Medicare eligibility due to: ☐Age ☐Disability ☐End Stage Renal

If Medicare covers one of your dependents: ☐Spouse ☐Other Dependent

His/Her Name:_____ Medicare #:_____

Effective Date of Part A:_____ Part B:_____

Is the Medicare eligibility due to: ☐Age ☐Disability ☐End Stage Renal

The above information is true and complete to the best of my knowledge.

_____ _____ _____

Member Signature Date Home Phone