

Coordination of Benefits 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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