



Coordination-of-Benefits Questionnaire

Date _____

Employee Name _____
Street Address _____
City, State Zip Code _____

Dear Employee Name:

Employee ID # _____
Group Name _____

Please complete the following coordination of benefits questions and return this letter to our office in the enclosed envelope within ten (10) days. Claim payments will be delayed until all requested information is received.

Do you or any members of your family have health or dental insurance other than US Able Administrators? Yes _____ No _____

Spouse's Name: _____

Spouse's Social Security Number: _____

Spouse's DOB: _____

Spouse's Employer: _____

Is spouse a current, active employee? Yes _____ No _____

If no, please supply retirement date: _____

Name of Other Insurance Carrier: _____

Medical _____ Dental _____ Both _____

Effective Date of Coverage: _____

Please list the names of all family members that are covered by another Carrier.

<u>Name</u>	<u>Date of Birth</u>	<u>Name</u>	<u>Date of Birth</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If other insurance is Medicare, please indicate Medicare number and effective date.

Medicare #: _____ Medicare Effective Date: _____

Please check the reason for Medicare coverage: Over 65 _____ Disabled _____ Kidney Disease _____

Has coverage for your dependent children been affected by a Divorce Decree or by custody?

Yes _____ No _____

(If yes, please include a copy of the page from the Divorce Decree that applies to this questionnaire.)

Sincerely,
US Able Administrators
Membership Division