COORDINATION OF BENEFITS

We require this form to be completed ANNUALLY, even if you do not have other coverage.

Samaritan Health Plans

{ DATE }

{ SBSB_FName } { SBSB_LName }
Member ID: { SBSB_ID }

Complete and return this form to us WITHIN 30 DAYS to prevent your claims from being delayed or denied. This form is needed to identify all the insurance plans that cover members of your family. For your convenience we have included a return envelope, or you can fax the form to us at 541-768-9356.

For questions, contact Customer Service at 541-768-4550 or toll-free at 800-832-4580 (TTY 800-735-2900), Mon. – Fri., 8 a.m. to 8 p.m.

DO YOU HAVE OTHER INSURANCE?

Are you or any member of this Samaritan policy covered by any other medical, dental, vision or pharmacy insurance policy, including any other Samaritan or Medicare policy?

❑ **No. If No, please sign, date here and return this form to us. You do not need to complete any other sections of this form.**

I certify that neither my dependent(s) nor I have other health insurance coverage.

Policyholder signature: _____ Date: _____

❑ **Yes**. If Yes, please complete complete all remaining sections of the form. Please use a separate piece of paper if you have more than one coverage or require more space.

SECTION A – DEPENDENT(S) ON SAMARITAN POLICY

Name:	Gender:	Relationship:	SSN:
Name:	Gender:	Relationship:	SSN:
Name:	Gender:	Relationship:	SSN:

SECTION B – OTHER INSURANCE COVERAGE

Other insurance name:	Start date (or cancellation date):
Type of insurance: ❑ Medical ❑ Dental ❑ Vision ❑ Pharmacy	Type of policy: ❑ Group ❑ Individual ❑ Student ❑ Medicare Supplemental
Mailing address:	

City:	State:	ZIP:	Phone:
Dependent(s) listed on the other insurance:			
Other insurance policyholder's name:	Other insurance ID number:		

Policyholder's date of birth:	Policyholder's SSN:		
Is the policyholder actively working for the group? ❑ Yes ❑ No			
Retired? ❑ Yes ❑ No Retirement Date:	On COBRA? ❑ Yes ❑ No Effective date:		
Policyholder's employer:			
Mailing address:			
City:	State:	ZIP:	Phone:
SECTION C – MEDICARE INFORMATION (If this does not apply, skip to Section D.)			
Do the policyholder and/or dependent(s) have Medicare? ❑ Yes ❑ No			
Name of person(s) with Medicare:	Medicare number:		
Effective date of Medicare Part A:	Effective date of Medicare Part B:		
Medicare entitlement: ❑ Age disability First date of disability: _____	❑ End Stage Renal Disease (ESRD) First date of dialysis for ESRD: _____		
Was ESRD started in a facility? ❑ Yes ❑ No	Was ESRD started as self-dialysis or home dialysis? ❑ Yes ❑ No		
SECTION D – COURT ORDER INFORMATION (If this does not apply, skip to Section E.)			
Is there a court order specifying who maintains health coverage for your dependent(s)*? ❑ Yes ❑ No You may use a separate piece of paper if you have more than one court order to address			
* Documentation of the court order may be requested from your Samaritan plan.			
If Yes, who is the person(s) required to maintain health coverage?			
List the name(s) of the dependent(s) this applies to:			
What is the policyholder's relationship to the child(ren)?	Who has custody of the child(ren) more than 50% of the time?		
SECTION E – POLICYHOLDER SIGNATURE			
I certify that the information I have provided regarding other health insurance is accurate and complete. **Policyholder signature: _____ Date: _____**			

Member ID: { SBSB_ID }

– ALERT – Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers). This alert is to advise that collection of HICNs, SSNs, or EINs for purpose of compliance with the reporting requirements under section 1 1 1 of Public Law 100-173 is appropriate. We use this information to communicate effectively with your other policies when needed.