

Coordination of Benefits Form



Policy Holder Name: _____

Policy Holder Date of Birth: _____

Employer Name & Subscriber ID number: _____

1. Do you or any of your dependents have other coverage? (Spouse or Children)

Yes _____ No _____

If Yes – Please check all coverages that apply: _____ Medical _____ Dental

2. Please list all dependents who are covered:

3. Name of Insurance Company: _____

4. Phone number (including area code): _____

5. Name of Policy Holder: _____

6. Policy Holders Date of Birth: _____

7. Policy Holders ID and/or Social Security Number: _____

8. Effective Date of Other Coverage: _____

9. Termination date of other coverage (if no longer active): _____

Signature _____ Date: _____

HealthEZ Claims Department

Return form to COBletters@healthEZ.com or fax to 952-896-4888

1-800-948-9450