EmblemHealth®

# Coordination of Benefits
# Other Health Insurance Questionnaire

Send completed form to EmblemHealth, 55 Water Street, New York, NY 10275-0718

## Subscriber Information

**EmblemHealth subscriber name:** _____
**EmblemHealth group number:** _____
**EmblemHealth ID number:** _____
**Subscriber phone number:** _____
**Subscriber email:** _____

**OTHER INSURANCE**

Are you or any other member of this EmblemHealth policy covered by another medical or dental insurance policy, other EmblemHealth policy, or Medicare?

☐ No. If ***No***, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."
☐ Yes. If ***Yes***, please complete all the fields below that pertain to the member(s) that has the other coverage.

## Section A *If this does not apply, skip to Section B.*

Check those that apply:
☐ Other health insurance ☐ Other dental insurance

What type of policy is this?
☐ Group policy ☐ Group insurance marketplace policy ☐ Individual policy
☐ Student policy ☐ Medicare supplement policy ☐ Direct pay policy

Other insurance carrier's name: _____

Address: _____

City, state, ZIP: _____

Phone number: _____

Dependent(s) listed on the other insurance:

_____

_____

Other insurance policyholder's name:

_____

Policyholder's date of birth**:** ____/____/_____ ID number: _____

Effective date of other insurance: ____/____/_____

If cancelled, cancellation date: ____/____/_____

Is the policyholder:

☐ Actively working for the group

☐ Retired, retirement date: ____/____/_____

☐ On COBRA, which began: ____/____/_____

Policyholder's employer: _____

Employer's address: _____

City, state, ZIP: _____

## Section B *If this does not apply, skip to Section C.*

**MEDICARE INFORMATION (Answer if your spouse is on your plan and Medicare eligible).**

Does the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare:_____

Medicare number, including letters: _____

Effective date of Medicare Part A (Hospital): ____/____/_____

Effective date of Medicare Part B (Medical): ____/____/_____

Effective date of Medicare Part C (Medicare Advantage): ____/____/_____

Effective date of Medicare Part D (Pharmacy): ____/____/_____

Rx Group:_____ Rx PCN: _____ Rx BIN:_____

Medicare entitlement:☐ Age☐ Disability* ☐End-stage renal disease (ESRD)*

* If the reason is for disability or ESRD, please provide the following:

First date of disability: ____/____/_____

First date of dialysis for ESRD: ____/____/_____

Was ESRD dialysis started in a facility? ☐ Yes ☐ No

Was ESRD dialysis started as self-dialysis or home dialysis: ☐ Yes ☐ No

Has a kidney transplant been performed? ☐ Yes ☐ No

If *yes*, please provide the date of the transplant: ____/____/_____

## Section C *If this does not apply, skip to Section D.*

### COURT ORDER INFORMATION

Is there a court order specifying a person(s) to maintain health coverage for any of your dependent(s)? ☐ Yes ☐ No
List the name(s) of the dependent(s) that this applies to:

_____

If yes, who is the person(s) listed to maintain health coverage? _____

What is the relation to the dependent(s)? _____

Who has custody of the dependent(s) more than 50% of the time?

_____

*If applicable, please attach a copy of any court order for dependent health coverage.*

## Section D

**Name(s) of dependent(s) on EmblemHealth policy:**

| Name | Relationship | Date of Birth | Sex | Social Security # |
|---|---|---|---|---|
| | | / / | | - - |
| | | / / | | - - |
| | | / / | | - - |
| | | / / | | - - |

I certify that the information provided is accurate. Any person who knowingly and with intent to defraud any insurance company or any other person who files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

*Policyholder signature:* _____ *Date:* ____/____/____