

**HERMANN ARE DISTRICT HOSPITAL
GROUP HEALTH PLAN COORDINATION OF
BENEFITS QUESTIONNAIRE**

PLEASE COMPLETE THIS FORM AND RETURN TO: **MERCY BENEFIT ADMINISTRATORS
PO BOX 14230
SPRINGFIELD, MO 65814**

MEMBER NAME: _____ MEMBER ID #: _____ CLAIMANT NAME: _____
(FOR YOUR REFERENCE, THIS INFORMATION IS AT THE TOP OF THE ACCOMPANYING LETTER)

AT THIS TIME (OR AT ANY TIME IN THE LAST 12 MONTHS), ARE/WERE YOU OR ANY MEMBERS COVERED UNDER THE HERMANN AREA DISTRICT HOSPITAL GROUP HEALTH PLAN (INCLUDING YOURSELF, YOUR SPOUSE OR CHILDREN), ALSO COVERED BY ANY OTHER HEALTH INSURANCE PLAN?

YES _____ NO _____

IF THE ANSWER IS "YES", PLEASE REFER TO THE OTHER INSURANCE CARD TO COMPLETE THIS SECTION:

OTHER HEALTH INSURANCE COMPANY NAME: _____ COMPANY PHONE #: _____

EFFECTIVE DATE: _____ GROUP #: _____ MEMBER ID#: _____

NAME OF POLICY HOLDER OF OTHER INSURANCE: _____

BIRTH DATE OF POLICY HOLDER OF OTHER INSURANCE: _____

DOES THIS OTHER INSURANCE COVER YOU, YOUR SPOUSE OR CHILDREN?

EMPLOYEE: YES _____ NO _____

SPOUSE: YES _____ NO _____ IF YES, SPOUSE NAME: _____

CHILDREN: YES _____ NO _____ IF YES, CHILDREN NAME(S) _____

TYPE OF COVERAGE: ACTIVE EMPLOYEE _____ RETIREE _____ COBRA _____

MEDICARE: AGE 65 _____ DISABILITY _____ END STAGE RENAL DISEASE _____

OTHER COVERAGE EFFECTIVE DATE: ____/____/____

OTHER COVERAGE TERMINATION DATE (IF APPLICABLE): ____/____/____

IF THERE ARE ANY DEPENDENT CHILD(REN) COVERED UNDER THE HERMANN AREA DISTRICT HOSPITAL GROUP HEALTH PLAN, PLEASE COMPLETE THE FOLLOWING:

IS THERE A COURT ORDER OR CUSTODY AGREEMENT TO CARRY COVERAGE ON THE CHILD(REN)? YES _____ NO _____

IF YES, WHICH PARENT/GUARDIAN IS SO ORDERED? _____

FOR WHICH CHILD(REN) DOES THE ORDER APPLY? _____

I ATTEST TO THE ACCURACY OF THE INFORMATION CONTAINED WITHIN THIS FORM:

MEMBER SIGNATURE _____

DATE: ____/____/____