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

FAX: 417-820-3816
email: sprgbenefitadmins@mercy.net

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: _____/_____/_____