



Coordination of Benefits Form

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Employer Name & Subscriber ID number: _____

1. Do you or any of your enrolled dependents have other coverage?

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 Termination date of other coverage (if no longer active): _____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

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