Coordination of Benefits Annual Member Questionnaire

Do you or your dependents covered under your Independent Health policy have any other medical or dental insurance, or received health care services for an accident, injury, illness or condition that was caused by a motor vehicle, employment or third party liability (i.e. slip and fall, medical malpractice, etc.)?
___ Yes (Complete sections A-F as applicable) ____ No (Please skip to section G)

Section A - Other Insurance

Insurance Carrier Name ________________________ Insurance Carrier Phone Number ______________________________ Effective Date ___/____/____ Termination Date ___/____/____

Insurance Carrier Address ____________________________ ____________________________ ____________________________ Policy Holder _______________ Policyholder´s ID number ________________________ Date of Birth ___/____/____

Coverage Includes: __ Medical __ Dental __Vision ___ Prescription

What type of policy is this? ***Please check all that apply:***

___ Insured through employer ___ Retired from Employer ___ Individual/ Direct Pay
___ Tricare ___ Medicaid/ Government plan ___ Student
___ On COBRA, which began ___/___/___ ___ Medicare ***(Please proceed to Section B)***
___ Veterans Administration Benefits ***(Please proceed to Section F)***

What is the policy holder's working status? ___ Active ___ Retired ___ Disabled
If retired, when did retirement or disability begin? ____/____/____
Employer Name (if applicable): ____________________________ Employer's Address: __________________________________ __________________________________
Employer's telephone number: ____________________________
Group/Plan Number: _____________________________________

Please list the first and last names of all dependents covered under this other insurance policy:

Coordination of Benefits Annual Member Questionnaire

<table>
<tr><th colspan="4">Section B - Medicare</th></tr>
<tr><td colspan="2">Medicare Beneficiary:</td><td colspan="2">Social Security Number:</td></tr>
<tr><td>Medicare Number</td><td rowspan="2">Type of coverage
____ Part A (Hospital)
Effective Date: ___/___/___
____ Part B (Medical)
Effective Date: ___/___/___
____ Part D (Drug)
Effective Date: ___/___/___</td><td colspan="2" rowspan="2">Medicare Eligibility Due to:
____ Age (65 years old)
____ Disability Date: ___/___/___
____ End-Stage Renal Disease
• Initial Dialysis Date ___/___/___
• Kidney Transplant Date ___/___/___</td></tr>
<tr><td>Are you Working?
Yes____ No____
If no, are you still receiving a paycheck?
Yes ____ No____
Retirement Date ___/___/___</td></tr>
</table>

Section C - Court Order Information – Complete only if divorced or legally separated
Has a court/divorce decree been issued mandating health care responsibility for dependent children?
Yes ____ ***(Please attach copy of the court decree)*** No_____
If yes, name(s) of the person(s) listed to maintain health coverage: ______________________________
Name(s) of the dependent(s) that this applies to: ____
What is the relationship to the dependent(s)? ____
Address of responsible party: Insurance Company: ______________________________
______________________________ Policy #________________ Effective Date: ___/____/____
____
Who has custody of the dependent(s) more than 50% of the time? _____________________________

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Section D - No-Fault Insurance due to a motor vehicle related condition

Date of accident/injury/illness/condition: ____/_____/_________

Which of the following were involved (check all that apply)?

☐ Automobile ☐ Motorcycle ☐ Recreational Vehicle ☐Pedestrian ☐ Other: __________________

Describe the physical injury (specify right or left)/condition:

____

Medication prescribed for the physical injury/condition:

____

Name of Prescribing Physician: ____

Name and address of Automobile Insurance Carrier: ____ ____ ____

Claim # or Policy #: ___________________________________

State Automobile is registered in: ___________________________________

Automobile Insurance carrier's telephone number: ____

Policyholder Name of Automobile Insurance: ___________________________________

Was any other person who is covered under your Independent Health policy involved in the accident?

☐ Yes ☐ No If yes, please provide name and injuries (specify right or left):

Name: _________________________________ Injury: __________________________________

Name: _________________________________ Injury: __________________________________

Name: _________________________________ Injury: __________________________________

If a motorcycle was involved, does the motorcycle owner have coverage for medical expenses through an Automotive Insurance carrier? ☐ Yes ☐ No ☐ N/A

Is there a lawyer involved? ☐ Yes ☐ No If yes, Lawyer's Name: ___________________________

Lawyer's Address: _____________________________ ____

Lawyer's Telephone Number: _______________________________

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Section E - Worker's Compensation due to an employment or work related condition

Date of accident/injury/illness/condition: ____/_____/_____

Describe the physical injury (specify right or left)/condition:

____

Medication prescribed for the physical injury/condition:

____

Name of Prescribing Physician: ____

Name and address of Workers' Compensation Carrier:

____
____
____
____

Workers' Compensation Board Case #:

____

Workers' Compensation Claim Number:

____

Workers' Compensation Carrier's Phone #:

____

Name and address of Employer:

____
____
____

Employer's Phone Number:

____

1. Did you file a claim with Workers' Compensation? ☐ Yes ☐ No
   (If no, please contact your employer to file a claim)
2. Was your Workers' Compensation claim denied? ☐ Yes ☐ No
3. Have you accepted a Section 32 settlement? ☐ Yes ☐ No

If you answered yes to question 2 or 3, please attach a copy of your Notice of Decision from the Workers' Compensation Board and return with this form.

Is there a lawyer involved? ☐ Yes ☐ No If yes, Lawyer's Name: ___________________________

Lawyer's Address: ____________________________

____

Lawyer's Telephone Number:

____

Please list the first and last names of all dependents covered under Worker's Compensation

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Section F – Veterans' Administration Benefits due to service-related injury or condition

Name of Veteran: ____ Relationship: ________________

Describe the service-related injury/condition:

____

____

Medication prescribed for the service-related injury/condition:

____

____

Name of Veteran: ____ Relationship: ________________

Describe the service-related injury/condition:

____

____

Medication prescribed for the service-related injury/condition:

____

____

Name of Veteran: ____ Relationship: ________________

Describe the service-related injury/condition:

____

____

Medication prescribed for the service-related injury/condition:

____

____

Coordination of Benefits Annual Member Questionnaire

Section G - Name of Dependents on Independent Health Policy (If applicable)				
______________________________	___________________	___/____/_____	____	____________________
Name	Relationship	Date of Birth	Sex	Social security Number
______________________________	___________________	___/____/_____	____	____________________
Name	Relationship	Date of Birth	Sex	Social security Number
______________________________	___________________	___/____/_____	____	____________________
Name	Relationship	Date of Birth	Sex	Social security Number
______________________________	___________________	___/____/_____	____	____________________
Name	Relationship	Date of Birth	Sex	Social security Number
______________________________	___________________	___/____/_____	____	____________________
Name	Relationship	Date of Birth	Sex	Social security Number
______________________________	___________________	___/____/_____	____	____________________
Name	Relationship	Date of Birth	Sex	Social security Number

The information provided above is true and accurate to the best of my knowledge and understanding.

______________________________	_______________	__________________________
Signature	**Date**	**Daytime Phone Number**