COORDINATION OF BENEFITS FORM

2020 UPDATE

FOR IDENTIFICATION PURPOSES, GROUP NAME, EMPLOYEE NAME AND EMPLOYEE ID MUST BE PROVIDED ON THIS FORM.

Your Employee Benefit Plan contains a "Coordination of Benefits" provision, which must be updated annually.

This provision means that when a patient is covered under more than one group plan, one payor becomes the "primary carrier" and the other becomes the "secondary carrier." The primary carrier must pay benefits before the secondary carrier can determine what benefits it will pay. This applies if you have more than one medical or dental plan, including Medicare coverage.

Please complete, sign and date the questionnaire on the back of this sheet. Then, return it with your enrollment packet OR mail to this address:

HealthFirst
PO Box 30541
Salt Lake City, UT 84130-0541

Please attach any additional pages as needed for your response(s). Be sure to keep a copy for your files.

You must return this form even if you do not have any other insurance coverage.

PLEASE NOTE: CLAIM(S) RECEIVED WITH 2020 SERVICE DATES MAY NOT BE PROCESSED UNTIL THIS FORM IS COMPLETED AND RETURNED. Additionally, if you do not return this form promptly, your claim may be denied. You must return this form within 180 days from the date of your Explanation of Benefits form, in order for that claim to be paid. Once we receive this form, all your 2020 claims will be processed as usual.

PLEASE COMPLETE THIS INFORMATION FOR ALL COVERED FAMILY MEMBERS.
This information may be provided over the phone by the Employee or Custodial Parent.
If there is a Divorce Decree or Child Support Order stating who is responsible for providing coverage, please be prepared to provide us with a copy of the order.

If you have questions, please contact the Customer Service Department.

*****ANNUAL UPDATE FOR 2020*****
***** PLEASE COMPLETE THIS INFORMATION FOR *****
***** ALL COVERED FAMILY MEMBERS FOR 2020. *****

Employee Name: _____

Employee ID: _____

Group Name/Employer: _____

The HealthFirst Subscriber is: Single □ Married □ Divorced □
*If single or divorced, skip to question # 2
*If married -
Spouse's Name: _____ Spouse's Date of Birth: _____
Spouse's Employer: _____

1. Is your spouse ***offered*** healthcare coverage through their employer? Yes □ No □
IF YES – did spouse ***elect* their employer insurance **Yes □ No □**
**IF NO – skip to question # 2
a) Name of Insurance Carrier or Plan: _____
b) Group #: _____ Policy #:_____ Effective Date: _____
c) What type of coverage is provided/elected? Medical □ Dental □
d) Who is covered on the spouse's policy?
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

2. Do you or any of your dependents have Medicare coverage? Yes □ No □
a) Name on Policy: _____ Policy #: _____
b) Reason for Medicare: Age □ Disability □ Renal Disease □ ALS □
c) Name of Insurance Carrier: _____ Effective Date: _____

3. Do you or your dependents have any healthcare coverage other than is listed above?
Yes □ No □
a) Policy Holder's Name: _____ Date of Birth: _____
b) Name of Insurance Carrier or Plan: _____
c) Group #: _____ Policy #:_____ Effective Date: _____
e) What type of coverage is provided? Medical □ Dental □
f) Who is covered on this policy?
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

4. Is there a Divorce Decree/Court Order stating who is responsible for coverage on dependents?
N/A □ Yes □ No □
IF YES, please attach a copy of this portion of the divorce decree.

_____ _____
Signature of Our Subscriber Date

IF ANY INFORMATION ABOVE CHANGES, YOU MUST NOTIFY HealthFirst IMMEDIATELY.
If you do not provide this information promptly, your claim may be delayed or denied.

ADDRESS HealthFirst • P.O. Box 132317 • Tyler, TX 75713-2317
WEBSITE www.hfbenefits.com
TEL 800.477.2287
FAX 903.509.5729