COORDINATION OF BENEFITS FORM

ANNUAL UPDATE FOR 2019

FOR IDENTIFICATION PURPOSES, GROUP NAME, EMPLOYEE NAME AND EMPLOYEE ID MUST BE PROVIDED ON THE NEXT PAGE OF 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.

In order to coordinate benefits appropriately, please complete, sign and date the questionnaire on the next page. Then, return it to our office at the following address:

HealthFirst
P.O. Box 132317
Tyler, TX 75713-2317

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 2019 SERVICE DATES MAY NOT BE PROCESSED UNTIL THIS FORM IS COMPLETED AND RETURNED. Additionally,

Additionally, if you do not return this form within 180 days, your claim may be denied.

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 any questions, please contact the Customer Service Department.

*****ANNUAL UPDATE FOR 2019*****
***** PLEASE COMPLETE THIS INFORMATION FOR *****
***** ALL COVERED FAMILY MEMBERS FOR 2019 *****

Employee Name: ______________________________
Employee ID: ______________________________
Group Name/Employer ______________________________

The HealthFirst Subscriber is: Single Married Divorced

*If single or divorced, skip to question # 2

1. Is your spouse offered healthcare coverage through their employer? Yes No
   a) Spouse's Name ____________________ Spouse's Date of Birth __________
   b) Spouse's Employer ______________________________
   c) Name of Insurance Carrier or Plan: ______________________________
   d) 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: __________

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: __________
   d) What type of coverage is provided? Medical Dental
   e) 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 OF THE ABOVE INFORMATION CHANGES, YOU MUST NOTIFY HealthFirst IMMEDIATELY, IN WRITING.