CO-ORDINATION OF BENEFITS STATUS FORM

(One fully completed, signed and dated required per family every 12 months OR earlier if there are changes)

P. O. Box 2592
Fort Wayne, IN 46801
800-258-0974
www.medpartnersonline.com

Employer/Group Name & Number	Employee's Name (Last, First, MI)	Social Security #

DO YOU OR ANY FAMILY MEMBER HAVE *OTHER* GROUP MEDICAL, DENTAL OR VISION COVERAGE INCLUDING MEDICARE? Yes_____ No _____
If Yes, please complete ALL information below. If other coverage terminated within the last 18 months, please indicate term date below for each dependent.

CHILDREN OF DIVORCED PARENTS: ___YES ___ NO
If Yes, have you provided a copy of the divorce decree in the past ___Yes ___No If no, please submit a copy of the most recent court document.

CHILDREN OF SINGLE PARENTS: ___ YES ___ NO
If Yes, please submit court document (if applicable) or indicate which parent has financial responsibility for insurance on the child. Name _____

IS ANY CHILD MARRIED: ___ Yes ___No. If yes, please indicate name and date of marriage. Name _____ Date of Marriage _____

ARE YOU RETIRED: Yes _____ No _____ IS YOUR SPOUSE RETIRED: Yes _____ No _____ Do you have a dependent child eligible for Medicare? Yes _____ No _____

Employee/Dependent (First & Last Name)	Custodial Parent's Name Date Of Birth	Non-Custodial Parent's Name Date Of Birth	Custodial Step-Parent's Name Date Of Birth	Non-Custodial Step-Parent's Name Date Of Birth	Other Policy Effect Date	Other Policy Term Date	*check all applicable other policies* Medical	Dental	Vision	Medicare
1) Employee	NOT APPLICABLE									
2) Spouse										
3) Dependent Child										
4) Dependent Child										
5) Dependent Child										
6) Dependent Child										
7) Dependent Child										

Insurance Company Name	Policy Number	Address	Phone #	Employee
Insurance Company Name	**Policy Number**	**Address**	**Phone #**	**Employee**

I CERTIFY THE ABOVE IS COMPLETE AND CORRECT. I AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PROVIDER TO RELEASE INFORMATION WHICH MAY BE NECESSARY TO DETERMINE BENEFITS PAYABLE UNDER THE PLAN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. THIS RELEASE OF INFORMATION EXPIRES ONE YEAR FROM THE RECEIVED DATE.

EMPLOYEES SIGNATURE _____ **DATE** _____

SPOUSE SIGNATURE _____ **DATE** _____

Return To:
MedPartners
P. O. Box 2592
Fort Wayne, IN 46801

Phone: 800-258-0974
Fax: 260-435-6995
www.medpartnersonline.com
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