COORDINATION OF BENEFITS FORM
(for those covered under this Plan)

This form can be completed online at www.WellSpanPopHealth.com under the Member, Forms area OR you can submit this form to our Customer Service Department at PO Box 2347, York, PA 17405, via fax to (717) 755-7190 or email pophealthbenefits@wellspan.org. Questions: Call us at (717) 851-6800 or (800) 842-1768 or email us at pophealthbenefits@wellspan.org.

A. SUBSCRIBER INFORMATION (Please print clearly)

Subscriber (employee) name _____ *Family ID #* _____

Subscriber's Employer ***WELLSPAN HEALTH*** *Subscriber Phone number* _____

FORM is being completed for: (please mark all that apply) SELF____SPOUSE____CHILDREN ____

Are you or your dependents <u>enrolled</u> in other health coverage other than this Plan? This can include Medicare, Medicaid or any other group health coverage.

YES _____ (Complete sections B & C) NO____ (Complete section C)

B. OTHER COVERAGE SECTION – please provide a copy of the other plan's card.

Dependent Name 1: _____Effective date: _____ Term date: _____
Subscriber Name: _____*Relationship to the subscriber:* _____
Plan Name: _____*Plan Phone number:* _____
If Medicare, circle reason for eligibility: Age Disability ESRD
Subscriber's date of birth: _____*Family Identification #:*_____
Coverage Type: Medical ____Rx____Dental ____Vision ____ Retiree ____COBRA_____
Coverage Level: Primary____Secondary_____Tertiary_____

Dependent Name 2: _____ Effective date: _____ Term date: _____
Subscriber Name: _____ *Relationship to the subscriber:* _____
Plan Name: _____*Plan Phone number:* _____
If Medicare, circle reason for eligibility: Age Disability ESRD
Subscriber's date of birth: _____*Family Identification #:*_____
Coverage Type: Medical ____Rx____Dental ____Vision ____Retiree ____COBRA_____
Coverage Level: Primary____Secondary_____Tertiary_____

Dependent Name 3: _____Effective date: _____ Term date: _____
Subscriber Name: _____ *Relationship to the subscriber:* _____
Plan Name: _____*Plan Phone number:* _____
If Medicare, circle reason for eligibility: Age Disability ESRD
Subscriber's date of birth: _____*Family Identification #:*_____
Coverage Type: Medical ____Rx____Dental ____Vision_____ Retiree ____ COBRA_____
Coverage Level: Primary____Secondary_____Tertiary_____

Use the back of this form for more dependents or for further explanation. If this coverage is the result of a court order, please attach a copy of the applicable order.

C. SUBSCRIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information according to the provisions of the Plan. I also understand that I must notify my employer, in writing, if there are any changes to the information I provided above. Failure to provide complete and accurate information may result in a delay in the processing of benefits.

Printed Name:_____

Signature:_____Date_____