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

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

A. SUBSCRIBER INFORMATION (Please print clearly)

Subscriber (employee) name __________________________________ *Family ID #* ____________________

Subscriber's Employer ______________________________*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 ____ *Dental* ____ *Vision* ____ *Retiree* ____ *COBRA*______

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 ____ *Dental* ____ *Vision* ____ *Retiree* ____ *COBRA*_______

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 _____ *Dental* ____ *Vision*_____ *Retiree* _____ *COBRA*______

Use the back of this form for more dependents or for further explanation.

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___________________________

Caution: Any person who knowingly and with intent to defraud any health plan or insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.