

COORDINATION OF BENEFITS

Primary Insured Name: _____ Client's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary's Member # _____ Primary Insured DOB: _____

Your Mental Health/Chemical Dependency benefit plan, which is administered by: _____ may contain a Coordination of Benefits (COB)/full time student provision. For TRS to be properly considered for any charges incurred by you or one of your dependents, we ask that you please complete and return the following.

SECTION I

1. Do you have other coverage through another group health plan? Yes _____ No _____
2. If so, are you covered as an active employee, or retiree? Yes _____ No _____
3. Please indicate the name of the carrier and effective date: _____
4. If you are married, is your spouse employed? Yes _____ No _____
5. If yes, name of spouse's employer _____ Spouse's date of birth _____
6. Does your spouse have group coverage through his/her employer? Yes _____ No _____ if yes, complete section II.
7. If you are a considered a dependent (25 years old or younger), are you a full time student? Yes _____ No _____
8. Last school attended _____ Last date attended _____

SECTION II

1. Name of spouse's insurance carrier: _____ Phone# _____
2. Group/Policy number: _____ Insured ID/SSN: _____
3. Effective Date: _____ Termination Date: _____ Family or _____ Individual coverage?

SECTION III

If you have children and you are legally separated or divorced, please complete the following:

1. Is there a court decree stating financial responsibility? Yes _____ No _____
2. Who has responsibility? _____
3. Who has custody of the children? _____
4. Does anyone other than the natural parents carry insurance on the dependent(s)? Yes _____ No _____

SECTION IV

1. Are you, your spouse, or your dependents covered under Medicare? Yes _____ No _____

If yes, please complete the following:

2. Name and date of birth of person(s) covered: _____
3. Medicare ID#: _____ Is Medicare due to disability? Yes _____ No _____

If yes, please list diagnosis (Type of illness): _____

4. Date of onset: _____ Date eligible for Medicare: _____

Do you have a part A? Yes _____ No _____ Do you have a part B? Yes _____ No _____

I certify that the above information is correct.

Client Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____