



3035 Lakeland Hills Boulevard
Lakeland, FL 33805-2225

Attention: ELIGIBILITY

EMPLOYEE NAME: _____

ADDRESS: _____

ID NUMBER: _____

Dear Participant:

Your group health plan policy contains a Coordination of Benefits (COB) provision that applies when you or any of your covered dependents has more than one health insurance policy.

Please complete, sign, and return the following questionnaire *within 15 days*. A prompt response will ensure accurate processing of claims.

Type of Insurance <input type="checkbox"/> Group Policy <input type="checkbox"/> Excess Policy <input type="checkbox"/> Medicare Supplemental Policy <input type="checkbox"/> Other					
Name of Other Dental Insurance Company			Name of Other Health Insurance Company		
Type of Policy Coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child Only <input type="checkbox"/> Children Only					
<input type="checkbox"/> Family <input type="checkbox"/> Employee & Spouse Only <input type="checkbox"/> Spouse Only					
Name of Policy Holder:			Date of Birth		Policy Effective Date
Employment Status	<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Self employed <input type="checkbox"/> Continuation of Coverage (COBRA)				
Persons Covered by Other Insurance	Date of Birth		Relationship	Social Security #	
	Month	Day	Year		
1.					
2.					
3.					
4.					
Please provide a copy of the insurance card or insurance information for each policy that covers the dependents listed above.					
Medicare Participant	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Medicare HIC #	Date Eligible for Part A _____ Part B _____	Effective Date For Part A _____ Part B _____	
Reason(s) for Medicare <input type="checkbox"/> Age 65 or older <input type="checkbox"/> Disability eligibility under age 65 <input type="checkbox"/> End Stage Renal Disease (ESRD)			Date of First Dialysis Treatment for ESRD		
Please send a copy of your Medicare card					
To the best of my knowledge, the information provided is true, accurate, and complete. My signature authorizes any Medicare carrier, intermediary, or any other insurance carrier or plan to make available to First Service Administrators, Inc. all information concerning providers, employers, physicians, and hospital claims filed by me or on my behalf regarding claims filed by me or on behalf of other covered dependents.					
Employee's Name (Please Print)				Today's Date	
Employee's Signature			Employee's Social Security Number		
Employee's email address: _____					