CITY OF Salem AT YOUR SERVICE

Health Insurance Coordination of Benefits Form

Please complete this form as soon as possible. Any delay in completing this form may cause a denial of claims payment until the information is received.

Subscriber and Dependent Information

Employee Name	Date of Birth	Social Security Number	Employer Use only: Group ID#
			☐ Kaiser: 3246 ☐ Cigna: 3345347 ☐ Moda Dental: 10000159 ☐ Willamette Dental: OR206

Do you have other health insurance coverage?

☐ YES ☐ NO

If YES, what other coverage do you have?

☐ Medical ☐ Prescription ☐ Vision ☐ Dental

Do your dependents covered on the City of Salem health plan have other health coverage?

☐ YES ☐ NO

If NO, what is the reason for no other coverage?

☐ No other coverage available ☐ Waived other coverage ☐ Waiting period. Eligible on _____

If YES, list dependents who have other coverage below.

Other Coverage	Relationship	Dependent Name	Are biological parents divorced or legally separated?
☐ Medical ☐ Vision ☐ Prescription ☐ Dental	☐ Spouse ☐ Domestic Partner		N/A
☐ Medical ☐ Vision ☐ Prescription ☐ Dental	☐ Child ☐ Stepchild ☐ Partner's Child		☐ YES ☐ NO If YES, complete next section.
☐ Medical ☐ Vision ☐ Prescription ☐ Dental	☐ Child ☐ Stepchild ☐ Partner's Child		☐ YES ☐ NO If YES, complete next section.
☐ Medical ☐ Vision ☐ Prescription ☐ Dental	☐ Child ☐ Stepchild ☐ Partner's Child		☐ YES ☐ NO If YES, complete next section.

Information Required for Children of Divorced or Legally Separated Biological Parents

Biological Parent Name	Date of Birth	Provides health benefits?	Primary residence?	Address
Biological Mother:		☐ YES ☐ NO	☐ YES ☐ NO	
Biological Father:		☐ YES ☐ NO	☐ YES ☐ NO	

☐ Decree stipulates joint custody ☐ Decree stipulates other parent must provide health benefits ☐ Decree does not stipulate any special provisions.
☐ Other, please explain:

A copy of the section of the court decree pertaining to health coverage or other documents may be requested.

Other Coverage

Medical / Prescription	Vision	Dental
Subscriber Name:	Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Relationship to Employee:	Subscriber Relationship to Employee:	Subscriber Relationship to Employee:
Insurance Carrier:	Insurance Carrier:	Insurance Carrier:
Carrier Address:	Carrier Address:	Carrier Address:
Carrier Phone:	Carrier Phone:	Carrier Phone:
Group #:	Group #:	Group #:
Subscriber ID#	Subscriber ID#	Subscriber ID#
Effective Date:	Effective Date:	Effective Date:
Coverage End Date:	Coverage End Date:	Coverage End Date:

Policy Type:	Coverage Type:	Policy Type:	Coverage Type:	Policy Type:	Coverage Type:
☐ Group-Employer ☐ Individual ☐ Medicaid ☐ Medicare Part A ☐ Medicare Part B	☐ Employee ☐ Retiree ☐ COBRA ☐ Other	☐ Group-Employer ☐ Individual ☐ Medicaid ☐ Medicare Part A ☐ Medicare Part B	☐ Employee ☐ Retiree ☐ COBRA ☐ Other	☐ Group-Employer ☐ Individual ☐ Medicaid ☐ Medicare Part A ☐ Medicare Part B	☐ Employee ☐ Retiree ☐ COBRA ☐ Other

Subscriber Acknowledgement and Signature

I hereby certify that the information and statements that contained in this form are complete and accurate to the best of my knowledge. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____

Employer Use Only

☐ Submitted to Insurance/TPA Date: _____ HR Representative: _____ Employee# _____ ☐ Tracking List (New hire only)