

Coordination of Benefits

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

Employee Information: Patient Name: MI Insured's I.D. Number: _____ Date: ____/ ___/ ____/ _____/ _____/ _____/ _____/ Home Address: City: ______ State: _____ ZIP: _____ **Coordination of Benefits** Is your Spouse or dependent employed? Yes 🗌 No 🗌 Is your Spouse or dependent retired? Yes No 🗌 If answer is Yes, give Social Security Number: Does your Spouse/Dependent have other health insurance? If yes, Spouse/Dependent Name with other Health Insurance Spouse/Dependent Employer or Former Employer Name and Address Name/Address and Phone Number of other Health Insurance Carrier Group Policy ID Number(s) of other Health Insurance Carrier Certification: I hereby certify that the information I have provided on this form is true and accurate. In the event any information is false or misleading, the plan administrator or employer may take appropriate action. In the event benefit payments are incorrectly or improperly made, I shall be fully responsible for repayment to the Plan of all costs, fees and expenses related to such improper or incorrect benefit payment, including a reduction in future payment of claims by the full amount of such improper or incorrect benefit payments. Employee Signature:

For Assistance Call 1-800-355-2583