COORDINATION OF BENEFITS QUESTIONNAIRE

UME
Underwriting Management Experts

Member Name: _____

Section A – Basic Information

1. Are you, your spouse, and/or dependents covered under another health, dental, and/or vision plan?

   ☐ Yes ☐ No

2. Is your spouse employed? ☐ Yes ☐ No

   Is your spouse eligible for other coverage through his/her employer? ☐ Yes ☐ No

   Employer Name: _____ Phone Number: _____

   Address: _____ City: _____ State: _____ Zip: _____

Section B – Policy Information — Only complete Section B if you answered "Yes" to Number 1 in Section A

1. Name of Other Insurance Carrier: _____ Type of Plan: ☐ Group ☐ Individual ☐ Retiree ☐ COBRA
2. Name of Policy Holder: _____ Date of Birth of Policy Holder: _____
3. Coverage Effective Date: _____ Coverage Termination Date: _____
4. Please list names of those covered under other plan:

   _____ ☐ Medical ☐ Dental ☐ Vision

   _____ ☐ Medical ☐ Dental ☐ Vision

   _____ ☐ Medical ☐ Dental ☐ Vision

Section C – Dependent Child(ren) Information

1. Are you or your spouse legally divorced or separated from the parent of any dependent child(ren) on this policy?

   ☐ Yes ☐ No

2. Does one parent/guardian have full custody of the child(ren)?

   ☐ Yes ☐ No

   If "Yes", which parent/guardian? _____ Which child(ren)? _____

3. Is one parent required by a court decree to provide health insurance coverage for the child(ren)?

   ☐ Yes ☐ No

   If "Yes", which parent/guardian? _____ Which child(ren)? _____

   If other coverage is in place due to a court order, please include the court ordered policy information in Section B above

Section D – Medicare — Attach a copy of your Medicare card

1. Policy Holder's Name | Medicare Coverage | Reason for eligibility under Medicare *(Check all that apply)*

   _____ ☐ A ☐ B ☐ C ☐ D ☐ Age *(65 or over)* ☐ Disability ☐ End Stage Renal

   _____ ☐ A ☐ B ☐ C ☐ D ☐ Age *(65 or over)* ☐ Disability ☐ End Stage Renal

2. If you checked Disability and/or End Stage Renal, attach a copy of the Medicare documentation.

Section E - Signature

I hereby certify that the above statements are true and correct to the best of my knowledge.

Member Signature _____ Date _____

WARNING: *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.*