SummaCare SM

Annual Coordination Of Benefits Questionnaire

CONTRACT INFORMATION
Employee Name:
SummaCare ID:

SECTION I - COVERAGE
Do you or any eligible dependents currently have or have had other medical, pharmacy, dental or vision insurance coverage within the last 12 months? ☐ NO ☐ YES
**If you checked NO please sign the bottom of this form **If you checked YES please complete section II of this form

SECTION II – OTHER INSURANCE INFORMATION			
POLICY HOLDER'S NAME:			
POLICY HOLDER'S DATE OF BIRTH:			
RELATIONSHIP TO EMPLOYEE:			
GROUP #:	ID #:	☐ ACTIVE ☐ RETIREE	
EFFECTIVE DATE:		TERM DATE (IF APPLICABLE):	
POLICY COVERS: ☐ MEDICAL+RX ☐ MEDICAL ONLY ☐ RX ONLY ☐ DENTAL ☐ VISION			
POLICY TYPE: ☐ SINGLE ☐ EMPLOYEE+SPOUSE ☐ EMPLOYEE+CHILD ☐ FAMILY			
EMPLOYER'S NAME:			
NAME OF INSURANCE COMPANY:			
ADDRESS OF INSURANCE COMPANY:			
CITY:	STATE:	ZIP:	PHONE:

DEPENDENT INFORMATION - Please list information below for all covered dependents	
DEPENDENT 1 NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	RELATIONSHIP:
DEPENDENT 2 NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	RELATIONSHIP:
DEPENDENT 3 NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	RELATIONSHIP:
DEPENDENT 4 NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	RELATIONSHIP:

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SECTION III - COURT ORDER (COMPLETE IF APPLICABLE)
Is there a standing "court order" for "medical coverage" for any dependent covered? ☐ NO ☐ YES **If yes, attach a copy of the complete court order to this questionnaire**
NAME OF CUSTODIAL PARENT:

SECTION IV – MEDICARE INFORMATION		
Do you or a member of your family have Medicare Part A, Part B and/or Part D? ☐ NO ☐ YES		
IF YOU ANSWERED "YES" ABOVE, WHO IS THE MEDICARE COVERAGE FOR? ☐ SELF ☐ SPOUSE ☐ DEPENDENT		
MEDICARE RECIPIENT NAME:		
MEDICARE ID NUMBER:		
EFFECTIVE DATE PART A:	EFFECTIVE DATE PART B:	EFFECTIVE DATE PART D:
Please indicate the reason and corresponding dates, if applicable, for the person with Medicare Coverage:		
☐ AGE 65	DATE MEDICARE PARTICIPANT REACHED AGE 65:	
☐ END STAGE RENAL	FIRST DATE OF DIALYSIS:	
☐ TRANSPLANT	DATE OF TRANSPLANT:	
☐ DISABILITY	DATE APPROVED FOR MEDICARE BENEFITS:	

EMPLOYEE SIGNATURE:	DATE:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claims containing a false or deceptive statement is guilty of insurance fraud.

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