



Coordination of Benefits (COB) Questionnaire

To ensure the proper processing of your health claims, you must provide the information requested on this form. Please complete Questions 1 and 3. Only complete Question 2 if your spouse and/or children have MUST coverage. Sign, date and mail to MUST PO Box 4579, Helena MT 59604

| | |
|--------------|---------------|
| Member Name: | Member ID: |
| Group Name: | Group Number: |

1. Do you (the member) have any health coverage (including Medicare coverage) other than that provided by your employer? Yes ___ No ___

If Yes, provide name of other insurance company: _____

Insurance Company Telephone Number: _____

Effective Date of Coverage: _____

Primary Insured's Name: _____

Primary Insured's ID Number or Medicare HIC#: _____

If Medicare, when was the effective date? _____

Primary Insured's Date of Birth: _____

Type of coverage: Medical ___ Dental ___ Vision ___ Prescription Card ___

If a Medicare disability, was the disability due to End Stage Renal Disease (ESRD)? Yes ___ No ___

If ESRD, when did dialysis treatments begin? _____

2. Do your covered spouse and/or dependent(s) have other health coverage? Yes ___ No ___

If Yes, provide name of other insurance company: _____

Insurance Company Telephone Number: _____

Effective Date of Coverage: _____

Primary Insured's Name: _____

Primary Insured's ID Number or Medicare HIC#: _____

Primary Insured's Date of Birth: _____

Type of coverage: Medical ___ Dental ___ Vision ___ Prescription Card ___

If a Medicare disability, was the disability due to End Stage Renal Disease (ESRD)? Yes ___ No ___

If ESRD, when did dialysis treatments begin? _____

Names of dependents covered by other plan: _____

Is coverage for this dependent provided as the result of a court order? Yes ___ No ___

If Yes, please attach a copy of the applicable court order.

3. May we call you if additional information is required? Yes ___ No ___

Area Code and Phone Number: (____) _____

Signature _____

Date _____

Thank you for responding to this questionnaire. If you have questions, please call our Customer Service Team at 1-800-845-7283.

Reminder: A response to this questionnaire is required to assure proper claims processing. We appreciate your cooperation.