COORDINATION OF BENEFITS

Samaritan Health Plan Operations

Samaritan Health Plans needs periodic updates regarding our members' other coverage. To properly process your claims we require that you provide the following information. **Please return this form WITHIN 30 DAYS whether or not you have any other coverage.**

MEMBER INFORMATION

Name:	Date:
Member ID #:	Phone:
Mailing address:	

OTHER EXISTING COVERAGE *

Are you, your spouse, or any other family member covered under another Group Health Insurance or Vision Plan?

❑ NO Please provide termination date if other coverage has terminated in the past 12 months: ______________________________

❑ YES **If yes is checked, please provide the following information:**

Names of everyone with other current coverage	Date of Birth	Insurance Company Name, Address, Phone #	Policy or ID Number	Social Security # (required by Medicare*)	Type of Coverage	
					❑ Medical ❑ Vision ❑ Retiree	❑ Dental ❑ RX ❑ COBRA
					❑ Medical ❑ Vision ❑ Retiree	❑ Dental ❑ RX ❑ COBRA

Name of Subscriber to Other Insurance:	Relationship to you:
Subscriber's Date of birth:	Original effective date of Other Coverage:

CHILD CUSTODY INFORMATION

Is the other coverage due to a Child Custody arrangement? ❑ NO ❑ YES **If yes is checked, please complete the following and attach a copy of either the court mandate information or your divorce decree.**

Child(ren)'s Name(s):	
Name and Address of Mother:	Date of birth:
Name and Address of Father:	Date of birth:

Who is court mandated to provide insurance coverage? (*circle one*) Father / Mother / Joint Mandate / No Mandate

Who has custody? (*circle one*) Father / Mother / Joint Custody	Date of Court Mandate or Custody Decree:

MVA OR WORKER COMPENSATION CLAIMS **

If you have been involved in a Motor Vehicle Accident (MVA) within the past 24 months, or have filed a Worker Compensation Claim (WC) please provide the following:

Name of person with MVA or WC claim	Claim Number	Date of Claim/Injury	Site on Body of Injury	MVA or WC Insurance Name, Address and Phone Number
□ WC □ MVA				
□ WC □ MVA				

I affirm the answers given are complete and correct. I am providing these answers in cooperation with the Coordination of Benefits Provision listed in the plan document.

Signature: ____ Date: ____________________

** See attached explanation*

*** Use the other side of this form if you need to provide additional information.*

For questions regarding this form, please call 541-768-4550 or 1-800-832-4580 (TTY 1-800-735-2900)