

**Independence Administrators
Coordination of benefits (COB) Questionnaire**

Please complete and return this questionnaire to:

Independence Administrators
OPL Department
P.O. Box 984
Horsham, PA 19044

This questionnaire helps us to coordinate your benefits with other health insurance you may have. Your response will help us to ensure claims are processed properly according to your health benefits plan.

If you have any questions, please call the Customer Service number on your Independence Administrators ID card.

QUESTIONNAIRE

1. I am covered under another health plan. Yes No
2. My dependents are covered under another health plan. Yes No

If the answer to question 1 or 2 is "Yes," please complete the following:

Name of Plan	
Plan Member Last Name	
Plan Member First Name	
Member ID #	
Effective Date of Coverage	
Type of Coverage (select all that apply)	<input type="checkbox"/> Health <input type="checkbox"/> Rx (Drug) <input type="checkbox"/> Dental <input type="checkbox"/> Vision

3. I am, or one of my dependents is, enrolled in Medicare. Yes No

If you answered "Yes" to question 3, please include a copy of the Medicare card and write the reason for entitlement here (for example: age, disability, dialysis): _____

4. Please provide a daytime phone number should we need to contact you: _____
5. Your member ID number is: _____

Print Name

Signature