Independence Administrators

Coordination of Benefits Questionnaire

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 we do not receive the completed questionnaire, your claims may be affected.
If you have any questions, please call the Customer Service number on your Independence Administrators ID card. Thank you for your cooperation in completing this questionnaire.

---

1. Print Name: _____
2. Member ID number: _____
3. I am covered under another health plan. ❑ Yes ❑ No
4. My dependents are covered under another health plan. ❑ Yes ❑ No

   If the answer to question 3 or 4 is "Yes," please complete the following about the other plan:

Employer Name/Plan Name			
Insurance Company Name			
ID#/Policy #			
Type of Coverage (*select all that apply*)	❑ Hospital ❑ Doctor ❑ Dental ❑ Vision ❑ Drug ❑ Medicare		
	Name	Birth Date	Effective Date*
Plan Member			
Spouse			
Dependent**			
Dependent			
Dependent			

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

   If you answered "Yes" to question 5, please include a copy of the Medicare card and write the reason for entitlement here (for example: age, disability, dialysis): _____

6. Please provide a daytime phone number in case we need to contact you: _____

_____ _____
Signature Date

* Please specify the appropriate effective date for each member if it differs from the Plan Member's effective date.
** To add more dependents, please attach an additional sheet of paper.

Please complete and return this questionnaire to:
Independence Administrators
c/o Processing Center
P.O. Box 21974
Eagan, MN 55121

or fax to: 215-761-0323