Lifetime
BENEFIT SOLUTIONS

COORDINATION OF BENEFITS QUESTIONNAIRE

Lifetime Benefit Solutions is committed to providing you with the highest quality of care and service.

Your health benefit plan includes a coordination of benefits clause that determines the primary source of payment when a member is covered by more than one health insurance policy. The terms of your health benefit plan require you to provide all of the information necessary to properly coordinate your benefit. Failure to provide this information may result in the denial of claims for you or your dependents. The information you provide assists us in the prompt processing of claims. In addition, it may help us to reduce or lower your out-of-pocket expenses and control premium cost.

Employee Name: _____ Employer: _____

ID #: _____ (Alternate ID # can be found on your ID card)

SECTION A: OTHER INSURANCE

Are you or is any member of your family enrolled in any other health or dental insurance program (including Medicaid)?

☐ No – Please go on to Section B
☐ Yes – Please complete the following:

Health Insurance Information (excluding Medicare)

Please provide the details of the other medical/dental coverage (excluding Medicare). If other insurance is Medicare, please go on to Section B.

Name of Policyholder of other coverage: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Is the Policyholder actively employed? ☐ Yes – Employment date: _____
☐ No

Employer name (if applicable): _____

Please provide details of the other Medical coverage:

Health Insurance Company Name, Address and Phone: _____

_____

Policy Number: _____ Effective Date (required): _____ Cancel Date: _____

Type of Contract: ☐ Self ☐ Family - Please list dependents including spouse:

Spouse: _____ Dependent: _____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

Type of coverage (check all that apply): ☐ Major Medical ☐ Hospital ☐ Drug ☐ Vision

Are you or your spouse enrolled in an IRS-qualified High Deductible Health Plan with a Health Savings Account (HSA)?

☐ Yes
☐ No

Please provide details of the other Dental coverage:

Dental Insurance Company Name, Address and Phone: _____

_____

Policy Number: _____ Effective Date (required): _____ Cancel Date: _____

Type of Contract: ☐ Self ☐ Family - Please list dependents including spouse:

Spouse: _____ Dependent: _____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

If this coverage is provided for dependent child(ren) whose natural parents are divorced, separated or were never married, it is necessary to attach a copy of the court decree which identifies what parent is responsible for providing health coverage. If the court decree does not specify who is responsible, then it will be necessary to provide a copy of the custody agreement for the dependent child(ren). If you have previously provided the court decree to us, you do not have to provide it again.

SECTION B: MEDICARE RELATED INFORMATION

Medicare Information Only (Please Refer to your Medicare Card)

Are you or any of your dependents eligible for Medicare?
☐ No
☐ Yes – Please complete the following:

Reason(s) for Medicare coverage (check all that apply):
☐ Over age 65
☐ Disabled
☐ End-Stage Renal Disease

Status of Policyholder under this policy:
☐ Actively Employed
☐ Retired – Retirement Date: _____

For You		**For Your Dependent**	
Name of Beneficiary:		Name of Beneficiary:	
Medicare Claim Number:		Medicare Claim Number:	
Part A effective date:		Part A effective date:	
Part B effective date:		Part B effective date:	
Part D effective date:		Part D effective date:	

I certify that the above information is true and correct. I understand that the purpose of this information is to assure appropriate coordination of benefits of all plans. If any of the above information changes, I will notify Lifetime Benefit Solutions, Inc.

Signature: _____ Date: _____

Please return this form to the address shown on the back of your ID card.