Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

COB QUESTIONNAIRE

Please complete and return this Coordination of Benefits (COB) form to **Health Advantage**. This form is required if you or your dependents have insurance coverage with more than one carrier so we can determine how your claims should be processed. Please mail completed form to:

Please send this completed form to the following address:
Health Advantage, Attention: COB Department, P.O. Box 8069, Little Rock, AR 72203-8069

Health Advantage Policyholder Name _____ Social Security Number _____

Health Advantage Group Number _____ Health Advantage Member ID Number _____

SECTION A - OTHER INSURANCE: *If this does not apply, skip to Section B.*

Are you or any other member of this Health Advantage policy covered by another medical or Medicare policy?

☐ NO If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance"

☐ YES If Yes, please complete all the fields below that pertain to the member(s) who has the other insurance

Mark those that apply: ☐ No other insurance ☐ Add other insurance ☐ Change in other insurance ☐ Termination of other insurance

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Please list Spouse and Dependent(s) on the other insurance:

First Name	Last Name	Relationship	Coverage Effective Date

Other Insurance Policyholder's Name _____ Policyholder's Date of Birth _____ ID Number _____

Effective Date of Other Insurance _____ If Cancelled, Cancellation Date _____

Is the policyholder: ☐ Actively working for the group ☐ Inactive ☐ Retired, retirement date: _____ ☐ On COBRA, which began: _____

SECTION B - MEDICARE INFORMATION *If this does not apply, skip to Section C.*

Policyholder/Subscriber Coverage (Yourself)

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Policyholder/Subscriber with Medicare Coverage	Date of Birth (MM/DD/YY)	Medicare Number, including alpha character(s) or SSN

Effective Date of Medicare Part A: _____ Effective Date of Medicare Part B: _____

☐ Active ☐ Retired Date of Retirement: _____

Reason for Medicare: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

Spouse Coverage

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Spouse Name	Date of Birth (MM/DD/YY)	Medicare Number, including alpha character(s) or SSN

Effective Date of Medicare Part A: _____ Effective Date of Medicare Part B: _____

☐ Active ☐ Retired Date of Retirement: _____

Reason for Medicare: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)*

SECTION C - COURT ORDER INFORMATION *If this does not apply, skip to Section D.*

Please complete this section for any dependent child(ren) listed in Section A when parents are divorced or legally separated, or have some other legal reason for providing coverage.

Name(s) of Child(ren): _____ _____

_____ _____

Parents are: ☐ Legally Seperated ☐ Divorced ☐ Never Married

Parent with custody: _____ ☐ Remarried ☐ Not Remarried

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ No ☐ Yes (If yes, please answer the questions below.)

Documentation of the court order MUST be attached with this form.

Name of Policyholder	Policyholder's Date of Birth (MM/DD/YY)

Other Insurer's Identification Number	Effective Date of Coverage

Other Insurance Carrier's Name	Phone Number

SECTION D - SIGNATURE

I understand that the information provided on this form is true, complete and correctly recorded and will be used by Health Advantage for coordination of benefits and adjudication of claims. My signature authorizes coordination of benefits under my health plan with other insurance plans that are subject to coordination of benefits and for recovery of funds from another party found to be responsible for claims. If the information provided on this form changes, I agree to notify Health Advantage.

Subscriber Signature Subscriber SSN Date

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.