**OTHER HEALTH INSURANCE FORM**

Your health plan may contain a Coordination of Benefits (COB) provision that applies to other healthcare insurance. As your health plan administrator, Healthcare Management Administrators (HMA) will work with other health insurance providers to coordinate your plan benefits and process your claims correctly.

Please complete and return this form to HMA by one of the following methods:

|  |  |  |  |
| --- | --- | --- | --- |
|  **Mail:** | HMA | **Fax:** | 1-866-458-5488 |
|  | Attn: COB Team | **Email:** | COBrequest3@accesstpa.com |
|  | PO Box 85016 |  |  |
|  | Bellevue WA 98015-5016 |  |  |

If any of the information on this form changes, please contact our Customer Care Team at 425-462-1000 or

1-800-869-7093. You can also update this information in your online account, myHMA, at **accesshma.com**.

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| --- |
| **SECTION 1 – EMPLOYEE INFORMATION** |
| Member Name (first name, middle initial, last name): |
| Group Number: | Member ID Number: |
| **SECTION 2 – OTHER INSURANCE** |
| Are you or any of your dependents enrolled in your group health plan covered by another medical insurance plan?  [ ]  Yes - If yes, please complete the fields below for the person(s) who have other coverage. [ ]  No - If no, please go to Section 3. |
| Type of policy: [ ]  Group [ ]  Individual [ ]  Student [ ]  Medicaid/State Plan  |
| Type of coverage: (Please check all that apply.) [ ]  Medical [ ]  Dental [ ]  Vision [ ]  Prescription |
| Other Insurance Carrier’s Name: | Phone Number:( ) |
| Effective Date of Other Insurance:  | If Cancelled, Cancellation Date: |
| Name of Person(s) Covered on this Other Insurance:  |
| Name of Policyholder for Other Insurance:  | Policyholder’s Date of Birth: | Policyholder’s ID Number: |
| Policyholder’s Employer:  |
| This policyholder is: [ ]  Actively working for the group [ ]  On COBRA as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Retired as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_   |
| **SECTION 3 – MEDICARE INFORMATION** |
| Are you or any of your dependents enrolled in your group health plan covered by Medicare? [ ]  Yes - If yes, please complete the fields below that pertain to the person(s) with Medicare coverage. [ ]  No - If no, please go to Section 4. |
| Name of Person(s) Covered by Medicare:  |
| Medicare Entitlement: [ ]  Age [ ]  Disability [ ]  End Stage Renal Disease (ESRD) |
| Health Insurance Claim Number (HICN), Including Alpha Characters: |
| Effective Date Medicare Part A:  | Effective Date Medicare Part B:  |
| **SECTION 4 – COURT ORDER INFORMATION** |
| Is there a court order specifying a person (or persons) to maintain health coverage for any of your dependents? [ ]  Yes - If yes, please complete the fields below for the person(s) subject to coverage and  **attach documentation of the court order**. [ ]  No - If no, please proceed to the custody fields below and complete this information.  [ ]  No - If no court order or custody decree, please proceed to Section 5.  |
| Name(s) of the person(s) ordered to maintain health coverage and relationship to the dependent(s): |
| Name(s) of the dependent(s) to subject to receive health coverage: |
| Person who has custody of the dependent(s) more than 50% of the time: |
| **SECTION 5 – EMPLOYEE SIGNATURE*****Please note that submitting this questionnaire to HMA constitutes a signature.*** |
|   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Policyholder Signature) (Date) |