

Email: AGACustomerService@aga-tpa.com

#### **COORDINATION OF BENEFITS QUESTIONNAIRE**

This this form MUST be returned within 30 days of receipt to notify Automated Group Administration of Medicare, Medicaid or other health insurance coverage for Coordination of Benefits (COB). FAILURE TO COMPLETE THIS FORM WILL RESULT IN DELAYS OR DENIALS OF CLAIMS PAYMENTS. Reason:  $\square$  Annual COB Update  $\square$  New Enrollee  $\square$  Add other insurance  $\square$  Termination of other insurance ☐ Add dependent/spouse Group # Group/Employer Name Member ID Name of Employee Date of Birth **Mailing Address** City State Zip **Email Address** Phone Number **Current Marital Status:** ☐ Single ☐ Married ☐ Widowed □ Divorced ☐ Legally Separated LIST EACH PERSON COVERED BY THIS PLAN. DOES ANYONE COVERED UNDER THIS PLAN (YOU, YOUR SPOUSE, OR YOUR DEPENDENTS) CURRENTLY HAVE OR ARE ELIGIBLE FOR ANY OTHER MEDICAL, DENTAL OR VISION COVERAGE? (i.e. Medicare, Medicaid, Student Insurance, Individual, or other employer sponsored plans) Other Plan Coverage This Plan Coverage Relationship Name of Family Member **Employer** Eligible covered under this Plan to Employee Date of (circle yes or no) (circle yes or no) for Birth Medical Dental Vision **Employer** Medical Dental Vision Y/NY/NY/NCoverage Y/NY/NY/NY/NEmployee Y/NY/NY/NY/NY/NY / N \* Y/NSpouse Y/N

\*Not Eligible for other coverage, why? \_\_\_\_\_

Y/N

Note: for dependent children of divorced, separated, or court-ordered parents, PLEASE complete SECTION 3.

Y/N

 $\frac{Y/N}{Y/N}$ 

Ш	No other insurance coverage - Please skip the rest of the questions, <u>sign</u> at the bottom and return.
	Yes, there is other insurance - Complete the entire form, <b>sign</b> and return.

Y/N

Y/N

### See Section 4: SIGNATURE (REQUIRED) ON PAGE 5



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# SECTION 1 OTHER HEALTH COVERAGE (Excluding Medicare – see Section 2)

If there	is more than	one plan providin	g health coverage	use a separate sheet o	f naner to share	this information
	is more man	One plan providin	g ileaitii coverage	use a separate sirect o	i babei to silaie	tilis illiolillation.

ir there is more than one	e pian providing health t	overage, use a se	parate sin	eet of paper t	.O Silale ti	iis iiiioi iiiatioii.	
Name of policy holder	Relationship to you	Social Security #		Employer		Birth Date	
Insurance Company Name	Insurance Company	Address				Phone #	
Member ID/Policy #	Group#	Effective Date		Cancellation	n Date	☐ Attach a	copy of applicable ID cards
Type of Coverage:	gle 🗌 Family	Type of Plan:	☐ Medical	☐ Dental	□Vision	☐ Prescription	Drug
SECTION 2 MEDICAR	RE COVERAGE						
If you, your spouse or a	dependent has Medica	re coverage, plea	se comple	te the follow	ving:		
Are <u>you</u> covered by Med	dicare? □No □Yes □.	Actively Employed	d □Retire	d			
	Over 65 $\square$ Disabled $\square$ E					is	-
	ve Date						
Hospital Part B – Effectiv	ve Date		py of app	icable ID card	t		
s your spouse covered b	oy Medicare? □No □Y	es □Actively Em	nploved $\Box$	Retired			
·	Over 65 Disabled D	•	•		irst Dialys	is	
_	ve Date	•		• •	•		-
	ve Date						
s vour dependent (Nam	ie	) covered by Me	dicare? [	]Yes ∏Activ	elv Emplo	ved	
	Disabled □ESRD (End S						
=	ve Date		-				
	ve Date						
SECTION 2 SPECIAL	CITUATIONS FOR DEPE	NDENT CHILDREN					
SECTION 3 SPECIAL	SITUATIONS FOR DEPE	NDENT CHILDREN					
Complete this section	on if you cover depende	nt children due to	o divorce,	separation, o	court orde	er, etc.	
Child Name:		(Use a separate sh		•			
	Full N	ame		ovide insurance or this child?	Do the	y have custody?	# of months child
Natural Father &			☐ Yes			es 🗆 No	lives with parent
Step Parent			☐ Yes		-	es 🗆 No	
Natural Mother &			☐ Yes		-	es 🗆 No	
Step Parent				□ No		es 🗆 No	
Step i di cit		*complete		mation for each		<u> </u>	
Is there a court order th	at determines responsib						
□ No □ Yes – attac	h copy of applicable sed	ction pertaining to	custody	and/or healt	h care co	verage.	
If there is more than on	e policy providing health	n coverage lise a	canarata (	heet of nane	r to share	this informatio	n·
Name of Policy holder	Social Security #	Relationship		ployer		Date	111
Insurance Company Name	Insurance Company Address	<u> </u>			Pho	ne #	
Marchael D/D !! !!	Carre II	Effective D. :	1.5				
Member ID/Policy #	Group #	Effective Date	Ca	ncellation Date	□ A   ID ca	ttach a copy of ap ards	plicable

Type of Coverage:

☐ Single

☐ Family

☐ Medical

☐ Dental

 $\square$  Vision

Type of Plan:



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## SECTION 3 SPECIAL SITUATIONS FOR DEPENDENT CHILDREN

SECTION 5 SPECIAL	SITUATIONS FOR DEPEN	IDENT CHIEDREN						
Complete this section	n if you cover depende	nt children due to	divor	ce, sepa	ration, cou	ırt order, et	С.	
Child Name:		(Use a separate she	eet for e	ach child.	)			
	Full N	ame			insurance	Do they have	custody?	# of months child
				ge for this	child?		_	lives with parent
Natural Father &			□ Y	es* 🗆	No	☐ Yes □		
Step Parent			□ Y	es* 🗌	No	☐ Yes □	No	
Natural Mother &			□ Y	es* 🗆	No	☐ Yes □	□ No	
Step Parent			□ Y	es* □	No	☐ Yes □	□ No	
	at determines responsible copy of applicable sec	oility for health car	re cove	rage or	=		e.	
f there is more than one	e policy providing health	n coverage, use a s	separat	e sheet	of paper to	share this	nformatio	n:
Name of Policy holder	Social Security #	Relationship		Employer	•	Birth Date		
Insurance Company Name	Insurance Company Address		<u> </u>			Phone #		
Member ID/Policy #	Group #	Effective Date		Cancellat	ion Date	☐ Attach ID cards	a copy of app	licable
Type of Coverage:	ngle   Family	Type of Plan:	1edical	☐ De	ntal □Vi	ision $\square$ Pre	scription Dru	g
	SITUATIONS FOR DEPE			ce, sepa	aration, co	urt order, et	c.	
Child Name:		(Use a separate sh	neet for	each child	.)			
	Full N	lame			insurance	Do they hav	e custody?	# of months child
				age for thi		_		lives with parent
Natural Father &			+	∕es* □	No		□ No	
Step Parent			□ \	∕es* □	No	☐ Yes	□ No	
Natural Mother &				∕es* □	No	☐ Yes	□ No	
Step Parent				∕es* □	No	☐ Yes	□ No	
		•	-		n for each "ye	es"		
□ No □ Yes – attac	nat determines responsi ch copy of applicable se	ction pertaining to	o custo	dy and,	or health			
	ne policy providing healt		separa					n:
Name of Policy holder	Social Security #	Relationship		Employe	r	Birth Date		
Insurance Company Name	Insurance Company Addres	S				Phone #		
Member ID/Policy #	Group #	Effective Date		Cancella	tion Date	☐ Attach	a copy of ap	plicable

☐ Medical

Type of Coverage:

☐ Single

☐ Family

Type of Plan:

 $\square$  Prescription Drug

□Vision

 $\square$  Dental



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## SECTION 3 SPECIAL SITUATIONS FOR DEPENDENT CHILDREN

Complete this section	n if you cover depende	nt children due to di	orce, separat	tion, court o	order, etc.	
Child Name:		(Use a separate sheet	or each child.)			
	Full N	anne	they provide ins verage for this ch		o they have custody?	# of months child lives with parent
Natural Father &			Yes* □ N	lo 🗆	☐ Yes ☐ No	
Step Parent			Yes* □ N	lo 🗆	☐ Yes ☐ No	
Natural Mother &			Yes* □ N	lo 🗆	☐ Yes ☐ No	
Step Parent			Yes* □ N	lo 🗆	☐ Yes ☐ No	
□ No □ Yes – attac	at determines responsik h copy of applicable sec e policy providing health	ction pertaining to cu	stody and/or	health care	_	n·
Name of Policy holder	Social Security #	Relationship	Employer	paper to si	Birth Date	II.
- Traine of Foliation	occial occarrey ii		2p.o/c.			
Insurance Company Name	Insurance Company Address	5			Phone #	
Member ID/Policy #	Group #	Effective Date	Cancellation	Date	☐ Attach a copy of ap ID cards	olicable
Type of Coverage: ☐ Sir	ngle 🗌 Family	Type of Plan:   Media	al 🗌 Denta	l □Vision	n 🔲 Prescription Dru	ıg
Complete this section	SITUATIONS FOR DEPE	ent children due to d	-	ition, court	order, etc.	
Child Name:		(Use a separate sheet				T
	Full f	tarric	o they provide in overage for this c		Do they have custody?	# of months child lives with parent
Natural Father &					☐ Yes ☐ No	
Step Parent			☐ Yes* ☐	No [	□ Yes □ No	
Natural Mother &			☐ Yes* ☐	No [	□ Yes □ No	
Step Parent			☐ Yes* ☐	No [	□ Yes □ No	
$\square$ No $\square$ Yes – <b>attac</b> If there is more than or	hat determines responsi ch copy of applicable se	bility for health care continuous for health care continuous to continuous a separate a separate as expensive	arate sheet o	ustody? r <b>health car</b>	hare this informati	on:
Name of Policy holder	Social Security #	Relationship	Employer		Birth Date	
Insurance Company Name	Insurance Company Addres	SS			Phone #	
Member ID/Policy #	Group #	Effective Date	Cancellatio	n Date	☐ Attach a copy of ap ID cards	pplicable

☐ Medical

☐ Dental

□Vision

Type of Coverage:

☐ Single

☐ Family

Type of Plan:

 $\square$  Prescription Drug



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No ☐ Yes — attach copy of applicable section performance is more than one policy providing health coverage Name of Policy holder Social Security # Relation  Insurance Company Name Insurance Company Address  Member ID/Policy # Group # Effective	Yes*	idid?  No	lives with parent
Step Parent  Natural Mother & Step Parent  Is there a court order that determines responsibility for No Yes – attach copy of applicable section per of the section pe	Yes*	No Yes No r each "yes" stody? health care coverage.  paper to share this inform Birth Date	
Natural Mother &  Step Parent  Is there a court order that determines responsibility for  In No	Yes*	No Yes No No Yes No reach "yes" stody? health care coverage.  paper to share this inform Birth Date	
Step Parent  s there a court order that determines responsibility for  No Yes − attach copy of applicable section pe  f there is more than one policy providing health covera  Name of Policy holder Social Security # Relation  Insurance Company Name Insurance Company Address  Member ID/Policy # Group # Effective	*complete Policy information for health care coverage or cuertaining to custody and/or age, use a separate sheet of	No Yes No reach "yes" stody? health care coverage.  paper to share this inform Birth Date	
s there a court order that determines responsibility for  No Yes – attach copy of applicable section pe  f there is more than one policy providing health covera  Name of Policy holder Social Security # Relation  Insurance Company Name Insurance Company Address  Member ID/Policy # Group # Effective	*complete Policy information for r health care coverage or cu ertaining to custody and/or age, use a separate sheet of	reach "yes" stody? health care coverage.  paper to share this inform  Birth Date	,
No Ves – attach copy of applicable section per f there is more than one policy providing health covera Name of Policy holder Social Security # Relation Insurance Company Name Insurance Company Address  Member ID/Policy # Group # Effective	r health care coverage or cu ertaining to custody and/or age, use a separate sheet of	stody? health care coverage. paper to share this inform Birth Date	ation:
Name of Policy holder Social Security # Relation  Insurance Company Name Insurance Company Address  Member ID/Policy # Group # Effective	<u>-</u>	Birth Date	
Member ID/Policy # Group # Effective			
		Phone #	
	e Date Cancellation	Date	of applicable
Type of Coverage: $\square$ Single $\square$ Family Type of	Plan:	I □Vision □ Prescriptio	n Drug
hild Name: (Use a	separate sheet for each child.)  Do they provide insi	urance Do they have custody	? # of months child
	coverage for this ch		lives with parent
Natural Father &	☐ Yes* ☐ N		
Step Parent	☐ Yes* ☐ N		
Natural Mother &	☐ Yes* ☐ N		
Chan Danant			
Step Parent	Tes* □ N  *complete Policy information for		
there a court order that determines responsibility for  No  Yes – attach copy of applicable section per	*complete Policy information for health care coverage or cust rtaining to custody and/or	each "yes" stody? health care coverage.	ation:
there a court order that determines responsibility for  No  Yes – attach copy of applicable section per	*complete Policy information for health care coverage or cus rtaining to custody and/or ge, use a separate sheet of	each "yes" stody? health care coverage.	ation:
s there a court order that determines responsibility for  No Ses – attach copy of applicable section per there is more than one policy providing health covera	*complete Policy information for health care coverage or cu- rtaining to custody and/or ge, use a separate sheet of	each "yes" stody? health care coverage. paper to share this informa	ation:
s there a court order that determines responsibility for  No	*complete Policy information for health care coverage or custraining to custody and/or ge, use a separate sheet of ship Employer	paper to share this information between the batter of the	
Insurance Company Name Insurance Company Address	*complete Policy information for health care coverage or custraining to custody and/or ge, use a separate sheet of ship Employer  Date Cancellation	paper to share this information Birth Date  Phone #  Date	f applicable

DepCob

Return completed form to:

Scan and Email: AGACustomerService@aga-tpa.com

Phone: (260) 489-6447