Automated Group Administration, Inc.
7605 Westfield Drive
Fort Wayne, IN 46825
Fax 260-489-0365
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: ☐ Annual COB Update ☐ New Enrollee ☐ Add other insurance ☐ 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)

Relationship to Employee	Name of Family Member covered under this Plan	Date of Birth	This Plan Coverage (circle yes or no)			Employer	Eligible for Employer Coverage	Other Plan Coverage (circle yes or no)		
			Medical Y / N	Dental Y / N	Vision Y / N			Medical Y / N	Dental Y / N	Vision Y / N
Employee			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
Spouse			Y / N	Y / N	Y / N		Y / N *	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N			Y / N	Y / N	Y / N

*Not Eligible for other coverage, why? ___________________

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

☐ No other insurance coverage - Please skip the rest of the questions, **sign** at the bottom and return.
☐ Yes, there is other insurance - Complete the entire form, **sign** and return.

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 providing health coverage, use a separate sheet of paper to share this information:

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 Date	☐ **Attach a copy of applicable ID cards**
Type of Coverage: ☐ Single ☐ Family		Type of Plan: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug		

SECTION 2 MEDICARE COVERAGE

If you, your spouse or a dependent has Medicare coverage, please complete the following:

Are you covered by Medicare? No Yes Actively Employed Retired
Reason for coverage: Over 65 Disabled ESRD (End State Renal Disease), Date of first Dialysis _____
Hospital Part A – Effective Date _____ Medicare Member ID _____
Hospital Part B – Effective Date _____ ☐ Attach a copy of applicable ID card

Is your spouse covered by Medicare? No Yes Actively Employed Retired
Reason for coverage: Over 65 Disabled ESRD (End State Renal Disease), Date of first Dialysis _____
Hospital Part A – Effective Date _____ Medicare Member ID _____
Hospital Part B – Effective Date _____ ☐ Attach a copy of applicable ID card

Is your dependent (Name _____) covered by Medicare? Yes Actively Employed
Reason for coverage: Disabled ESRD (End State Renal Disease), Date of first Dialysis _____
Hospital Part A – Effective Date _____ Medicare Member ID _____
Hospital Part B – Effective Date _____ Attach a copy of applicable ID card

SECTION 3 SPECIAL SITUATIONS FOR DEPENDENT CHILDREN

Complete this section if you cover dependent children due to divorce, separation, court order, etc.

Child Name: _____ (Use a separate sheet for each child.)

	Full Name	Do they provide insurance coverage for this child?	Do they have custody?	# of months child lives with parent
Natural Father &		☐ Yes* ☐ No	☐ Yes ☐ No	
Step Parent		☐ Yes* ☐ No	☐ Yes ☐ No	
Natural Mother &		☐ Yes* ☐ No	☐ Yes ☐ No	
Step Parent		☐ Yes* ☐ No	☐ Yes ☐ No	

*complete Policy information for each "yes"

Is there a court order that determines responsibility for health care coverage or custody?
☐ No ☐ Yes – **attach copy of applicable section pertaining to custody and/or health care coverage.**

If there is more than one policy providing health coverage, use a separate sheet of paper to share this information:

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SECTION 4 SIGNATURE (REQUIRED)

I declare that all statements on this form are complete and true and I understand that they are the basis on which benefits are made available under the plan.

Date: _____ Employee Signature: _____ Name (print): _____

Return completed form to: Scan and Email: AGACustomerService@aga-tpa.com
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