Coordination of Benefits Questionnaire

As a employee and/or dependent enrolled in an Employer Sponsored Insurance Plan, it is a requirement to provide other health coverage information. The Coordination of Benefits (COB) Questionnaire listed below contains questions about other forms of medical insurance you have. COB helps to ensure that members covered by more than one plan will receive the benefits they are entitled to while avoiding overpayment by either plan. Coordinating benefits is on one of the ways to keep premiums at a minimum. Even if you do not have other medical insurance, please complete and sign the form. This will help prevent delays in paying medical claims on your behalf.

Are you covered as the Enrollee or Dependent: ☐ Enrollee ☐ Dependent

ENROLLEE INFORMATION
Name:
DOB:
Member ID:
Gender (Check One): ☐ M ☐ F
Group Name:
DEPENDENT INFORMATION
Name:
DOB:
Member ID:
Gender (Check One): ☐ M ☐ F
OTHER MEDICAL COVERAGE
Do you have other medical coverage? (Check One): ☐ Yes ☐ No
If Yes, Name of Insurance Company:
Address of Insurance Company:
Telephone Number:
Policy Number:
Effective date of plan:
Is this Plan Medicaid? (Check One): ☐ Yes ☐ No

Member Signature: ____

Date: ______________________________

Completed form and submit to CHP via mail, fax or email:

Consolidated Health Plans, Inc. | 2077 Roosevelt Ave. | Springfield, MA 01104
Fax: 413-733-4612 | Email: customerservice@wellfleetinsurance.com

Questions? Please call CHP Customer Service at 877-657-5035