Other Insurance Coordination of Benefits

BENEFIT ADMINISTRATOR USE ONLY
Date Received: ____________________
Date Entered into Bswift: ______________

Applicant Name: ______________________________ Social Security Number: ________________

Please complete this form if **You** or a **Family Member** have other health insurance coverage such as:

- Coverage through a spouse's employer
- Coverage through a former employer
- Union coverage (other than through your current employer)
- Medicaid (limited/low income)
- New York State Exchange
- Medicare (persons over age 65, under age 65 with certain disabilities)
- An open workers' compensation case
- A motor vehicle accident/injury

Other Medical Health Insurance Information. Attach additional sheet if necessary; provide copy(ies) of ID cards to Employer.

Policyholder's Name: ______________________

Name of Person(s) with Other Insurance:

____
(Last) (First) (M.I.) Social Security Number

____
(Last) (First) (M.I.) Social Security Number

____
(Last) (First) (M.I.) Social Security Number

____
(Last) (First) (M.I.) Social Security Number

Name of Insurance Company:
____

Address:
____

Telephone Number:
____

Policy ID #:
____

Effective Date of Coverage:
____

Coverage Includes (check appropriate boxes):

Medical	☐ Yes	☐ No	Dental	☐ Yes	☐ No
Hospital	☐ Yes	☐ No	Vision	☐ Yes	☐ No
Prescription	☐ Yes	☐ No			

Workers' Compensation Claim

Date of Injury/Accident: ______________________
Name of Injured Person:
____
(Last) (First) (M.I.) Social Security Number

Injury/Injuries:
____
Employer's Name Telephone No.
____
Employer's Compensation Carrier, Address, Telephone Number:

Name of Insurance Company:
____
____
____

WCB No.:______________ Claim No.: ______________

No-Fault (Motor Vehicle Accident)

Date of Accident: ______________________
Family Members Involved:
____
(Last) (First) (M.I.) Social Security Number
____
(Last) (First) (M.I.) Social Security Number

Name of Insurance Company:
____

Telephone Number:______________________
Claim No.:______________________
Medical Injuries: ☐ Yes ☐ No

Medicare Information – Complete if You, your Spouse or Dependent(s) have Medicare insurance; provide copy of ID card(s) to Employer

Applicant Name: ______________________ Medicare No.: ______________
Enrolled in Part A Hospital Coverage Effective Date: ______________________
Enrolled in Part B Medical Coverage Effective Date: ______________________
Reason for Medicare Eligibility: Over Age 65 ☐ Disabled (under 65 years old) ☐ Disabled but actively working ☐
I am Retired (Retirement Date): ______________________
I am Actively Employed: Full-time ☐ Part-time ☐ Do you have health insurance with the Employer listed below? ☐ Yes ☐ No
Employer Name, Address: ______________________

Spouse/Dependent: Name: ______________________ Medicare No.: ______________
Enrolled in Part A Hospital Coverage Effective Date: ______________________
Enrolled in Part B Medical Coverage Effective Date: ______________________
Reason for Medicare Eligibility: Over Age 65 ☐ Disabled (under 65 years old) ☐ Disabled but actively working ☐
I am Retired (Retirement Date): ______________________
I am Actively Employed: Full-time ☐ Part-time ☐ Do you have health insurance with the Employer listed below? ☐ Yes ☐ No
Employer Name, Address: ______________________

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