Please save this form to your computer. Complete the questionnaire and fax your reply to 419-423-5834 or mail to EBSO, Inc., P.O. Box 928, Findlay, OH 45839.

Coordination of Benefits Questionnaire

PLAN MEMBER NAME: _____

GROUP NUMBER: _____ PLAN MEMBER ID: _____

1. Other Employment Information for your Spouse:

Is your spouse employed?	☐ Yes	☐ No
Is Health Insurance available through your spouse's employer?	☐ Yes	☐ No
If yes, has your spouse declined coverage?	☐ Yes*	☐ No

Other Employment Information for your Adult Dependent Child(ren) (Age 19-26)

Is your Adult Dependent Child employed?	☐ Yes	☐ No
Is Health Insurance available through your child's employer?	☐ Yes	☐ No
If yes, has your child declined coverage?	☐ Yes	☐ No

***Your Employer may require your spouse or adult dependent child to enroll on his/her Health Plan. Consult your Plan Document, Benefit Booklet or Human Resource Department.**

Are you, your spouse, and/or your dependents covered under any other Health, Dental or Vision Policy?

☐ **Yes (Please complete sections 2 and 3)** ☐ **No (Please skip to section 4 and sign)**

2. Other Health/Dental/Vision Insurance Information for Spouse:

Name: _____

Birth Date: _____ Identification Number: _____

Employer Name: _____

Employer Address _____

City, State and Zip Code: _____

Other Insurance Company Name: _____

Address, City, State, Zip Code: _____

Telephone: _____ Policy/Group #: _____

Type of Policy: (Check all that apply)

Medical	☐ Family	☐ Single	Effective Date: _____
Dental	☐ Family	☐ Single	Effective Date: _____
Vision	☐ Family	☐ Single	Effective Date: _____

Does the other insurance cover prescription drugs, even if subject to deductible and/or coinsurance?

☐ Yes ☐ No

PLAN MEMBER NAME: _____

GROUP NUMBER: _____ PLAN MEMBER ID: _____

Please list the first and last name(s) of any other family members covered by spouse's insurance.

1) 2) 3)

Other Health/Dental/Vision Insurance Information for Adult Dependent (19-26). (If more than one Adult Dependent, please submit a separate sheet.)

Name of Dependent: _____

Birth Date: _____ Identification Number: _____

Employer Name: _____

Employer Address _____

City, State and Zip Code: _____

Other Insurance Company Name: _____

Address, City, State, Zip Code: _____

Telephone: _____ Policy/Group #: _____

Type of Policy: (Check all that apply)

Medical	☐ Family	☐ Single	Effective Date: _____
Dental	☐ Family	☐ Single	Effective Date: _____
Vision	☐ Family	☐ Single	Effective Date: _____

Does the other insurance cover prescription drugs, even if subject to deductible and/or coinsurance?
☐ Yes ☐ No

3. Financial Responsibility Information:
If you are a single or divorced, have dependent children or cover stepchildren, foster children or under legal guardianship or QMCSO, please complete the following questions:

Is there a court decree or QMCSO establishing financial responsibility? ☐ Yes ☐ No
If yes, who has financial responsibility? Name: _____
Relationship: _____
Primary Resident of the dependent(s): _____
If both parties are to maintain insurance on the children, which parent has custody? _____
Please include a copy of the court decree or QMCSO with this form if not previously submitted.

4. Signature:
I certify that the above information is correct and accurate to the best of my knowledge.
EBSO, Inc. Plan Member: _____ Date: _____
EBSO, Inc. Plan Member ID: _____