Avera Health Plans

Coordination of Benefits
Request for Information Form
For Individual Policyholders

Your health insurance contains a Coordination of Benefits provision which applies to situations where there may be overlapping coverage for you or your dependents. This form is used for the sole purpose of gathering information about other health care carriers who provide health benefit coverage for you and/or your dependent(s).

IMPORTANT NOTE: This form must be completed and mailed to us within 10 business days to ensure accurate and timely processing of your claims.

Are you, your spouse or any of your dependents who are covered by us, also covered by another health insurance policy?

☐ No If No, please complete Section 1 and mail this form to us.
☐ Yes If Yes, please complete all the applicable sections beginning with Section 1 and mail this form to us.

SECTION 1. AVERA HEALTH PLANS SUBSCRIBER INFORMATION (Please print.)

Subscriber Name: _____ Subscriber Number: _____

Subscriber Mailing Address: _____

City: _____ State: _____ ZIP: _____

I certify that the information furnished by me on this form is true and correct at this time and agree to inform Avera Health Plans of any changes.

Subscriber Signature: _____ Date: _____ / _____ / _____

SECTION 2. SPOUSE INFORMATION (If not married, skip to Section 3.)

Spouse's Name: _____ Spouse's Date of Birth: _____ / _____ / _____

Spouse's Current Employer, Company Name: _____

Spouse's Social Security Number: _____

SECTION 3. OTHER COVERAGE INFORMATION

Other Insurance Name: _____ Other Insurance Member ID Number: _____

Other Insurance Phone Number: (_____) _____ - _____ Type of Policy: ☐ Group Policy ☐ Individual Policy

Policy Effective Date: _____ / _____ / _____ Policy End Date: _____ / _____ / _____

Policyholder's Name: _____ Policyholder's Date of Birth: _____ / _____ / _____

Policyholder's Employer Name: _____

If group policy, is the policyholder:

☐ Full-Time Employee
☐ Covered Through COBRA
☐ Retired / Date of Retirement _____ / _____ / _____

Covered Benefits:

☐ Medical
☐ Dental
☐ Vision
☐ Pharmacy

Name(s) of covered dependent(s) with dual coverage:

_____
_____
_____

Relationship to Policyholder:

_____
_____
_____

Please continue to the second page.

SECTION 4: ADDITIONAL INFORMATION

If you are divorced or legally separated from the policyholder in Section 3 and you have covered dependents with us, complete Section 4. (If not, proceed to Section 5.)

Date of divorce or legal separation: _____ / _____ / _____

Other Biological Parent's Name: _____ Other Biological Parent's Date of Birth: _____ / _____ / _____

Name of person who has been awarded legal custody of the child(ren): _____

Name(s) of covered dependent(s)

_____

_____

_____

Select One*:

☐ Divorce decree states _____must provide health insurance.
(Insert name here.)

☐ Divorce decree does not state any special provisions pertaining to health insurance.

☐ Other, please explain: _____

**A copy of the section of your court decree pertaining to health insurance or other documents must be provided to support your response.*

SECTION 5. MEDICARE COVERAGE INFORMATION

Do you or any of your dependents on this policy also have Medicare coverage?

☐ Yes, complete the following for those on Medicare

☐ No, you are done. Please mail completed form to Avera Health Plans.

If more than one family member has Medicare coverage, please submit a form for each covered member.

Member Eligible for Medicare: _____ Medicare Number: _____

Effective Date of Part A: _____ / _____ / _____ End Date of Part A: _____ / _____ / _____

Effective Date of Part B: _____ / _____ / _____ End Date of Part B: _____ / _____ / _____

Effective Date of Part D: _____ / _____ / _____ End Date of Part D: _____ / _____ / _____

Reason for Medicare Coverage:

☐ Age 65 or older

☐ Disability, date disability began: _____ / _____ / _____ Date disability ended: _____ / _____ / _____

☐ End-Stage Renal Disease, date dialysis treatment began: _____ / _____ / _____

After you have completed this form, please mail to:
Avera Health Plans, Attn: Enrollment
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
Avera Health Plans
3816 S. Elmwood, Suite 100,
Sioux Falls, SD 57105-6538

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Avera Health Plans

Getting Help in other Languages

Language assistance services are available free of charge. Our Service Center is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- US CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-322-2115 (رقم هاتف الصم والبكم: 1-800-877-1113.
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ. နမၤနဲ့ ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢၤ နီတမံၤဘဉ်သ့နူဉ်လီၤ. ကိး:1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (TTY: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113)
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113)
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-322-2115 (TTY: 1-800-877-1113)។