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 Code: __________

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 of this form.

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: ______________________________

Mail to Avera Health Plans, Attn: Enrollment, 5300 S Broadband Ln, Sioux Falls, SD 57108-2221 or fax to 605-322-4689. You may send it electronically by email to ahpenrollment@avera.org
Our Customer Care Team is available Monday through Friday at 605-322-4545 or toll-free at 888-322-2115

AveraHealthPlans.com