

COORDINATION OF BENEFITS (COB) FORM Request for Other Coverage Information



This form is a request for other coverage information we must have in order to update your insurance information and provide proper coverage.

INSTRUCTIONS: Print clearly in black ink. Complete the form in full, sign, and return it to PEEHIP using **one** of the following methods:

Online: <https://mso.rsa-al.gov/> (the fastest, preferred method)

Mail: PEEHIP, P.O. Box 302150, Montgomery, AL 36130

Email: peehipinfo@rsa-al.gov (Scan front and back)

If you, your spouse and/or dependent children are covered under PEEHIP and have any other insurance coverage, **EXCLUDING MEDICARE AND PEEHIP**, please indicate the other coverage on this form or **online** at <https://mso.rsa-al.gov/>. Failure to timely submit this form will result in your account being placed on claim hold and may cause a denial of medical and prescription claims.

SECTION A. PEEHIP SUBSCRIBER INFORMATION					
SSN:	First and Last Name:	Telephone Number: ()	Cell Phone Number: ()	Email Address:	
SECTION B. OTHER INSURANCE COVERAGE INFORMATION, EXCLUDING MEDICARE AND PEEHIP (Check all that apply)					
<input type="checkbox"/> Yes <input type="checkbox"/> No - I have/had other insurance coverage while covered by PEEHIP. <input type="checkbox"/> Yes <input type="checkbox"/> No - My spouse has/had other insurance coverage while covered by PEEHIP. <input type="checkbox"/> Yes <input type="checkbox"/> No - My dependent child(ren) has/had other insurance coverage provided by my spouse and/or other insurer while covered by PEEHIP.					
If you answered "Yes" to any of the above, you must complete the Insurance Company information below. If you answered "No" to all of the above, skip to Section C.					
LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)					
Name of Policy Holder	Date of Birth	Contract/Policy No.	Effective Date of Coverage	Termination Date (if applicable)	Insurance Co. Phone No. ()
Name of Insurance Company (check one)		Coverage Provided Through	Type(s) of coverage (check all that apply)		
<input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> VA <input type="checkbox"/> SEIB/Local Govt. <input type="checkbox"/> Other: _____		<input type="checkbox"/> Current Employer <input type="checkbox"/> Former Employer <input type="checkbox"/> Other	<input type="checkbox"/> Hospital/Medical with Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Hospital/Medical without Prescription Drug <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug Only Note: HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Drug Coverage		
Are you or any of your PEEHIP dependents covered as dependents on this insurance policy? <input type="checkbox"/> Yes-- ▶ List each dependent below <input type="checkbox"/> No 					
Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for health care expenses? (check <u>first</u> that applies)** Copy of Divorce Decree Required	
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree	
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree	
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SEE REVERSE SIDE – THIS FORM CONTAINS MORE INFORMATION



LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)

Name of Policy Holder	Date of Birth	Contract/Policy No.	Effective Date of Coverage	Termination Date (if applicable)	Insurance Co. Phone No. ()
Name of Insurance Company (check one) <input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> VA <input type="checkbox"/> SEIB/Local Govt. <input type="checkbox"/> Other: _____		Coverage Provided Through <input type="checkbox"/> Current Employer <input type="checkbox"/> Former Employer <input type="checkbox"/> Other	Type(s) of coverage (check all that apply) <input type="checkbox"/> Hospital/Medical with Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Hospital/Medical without Prescription Drug <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug Only <i>Note: HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Drug Coverage</i>		

Are you or any of your PEEHIP dependents covered as **dependents** on this insurance Yes--- ▶ *List each dependent below*
 No

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for health care expenses? (check <u>first</u> that applies)** Copy of Divorce Decree Required
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child--- ▶ <input type="checkbox"/> Yes / <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree
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Action Required: If you have indicated that you, your spouse, or your dependent child is insured under another Insurance Plan, you are required to provide a copy of the front and back of the insurance card for each card.

****If applicable, you must provide a copy of the section of the Court Order/Divorce Decree pertaining to health coverage or other documents to support your response.**

SECTION C. SUBSCRIBER CERTIFICATION

Statement: Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. It is fraudulent to submit information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse PEEHIP for any money it was induced to pay as a result of the information I provided. Receipt and/or completion of this form is not a guarantee of eligibility. I further authorize the release of any pertinent information from any source available to PEEHIP to verify the status of my employment.

Subscriber Signature _____ Date ____/____/____

HELPING YOU UNDERSTAND WHY THE INFORMATION IS NEEDED

COORDINATION OF BENEFITS. WHAT IS IT? Coordination of Benefits is designed to keep your rates as low as possible by eliminating excess payments. It keeps the cost of your medical care down without affecting the way you receive care. Oftentimes, members and their dependents are covered by two insurance plans. Working spouses cover each other and children are often covered on both parents' plans. When a PEEHIP member is covered by more than one health plan, the payment of his/her benefits is coordinated between the two plans.

HOW COORDINATION WORKS. If you have more than one plan and you receive services or supplies that are covered under both plans, this is how your benefits are coordinated:

The primary plan pays the full extent of its benefits. PEEHIP uses the first of the following rules that applies:

1. The benefits of the plan that covers you as an employee will be paid before the plan that covers you as a dependent. However, if you are eligible for Medicare coverage and Medicare is primary to your plan and your spouse has active coverage through an employer, then your plan pays third.
2. For claims on dependent children, the benefits of the parent's plan whose birthday falls earlier in the calendar year will be primary (this is known as the birthday rule) unless the parents are separated or divorced, in which case:
 - a. If a court decree specifies one parent cover the child's medical care, that parent's plan is primary.
 - b. If there is no court decree specifying coverage, the plan covering the parent with custody will be primary.
 - c. However, if the parent with custody remarries, the plan covering that parent will be primary, the plan covering the step-parent will be secondary, and the plan covering the parent without custody will be third.
 - d. If a court decree specifies joint custody but does not say which parent covers the child's medical care, then the birthday rule is used.
3. If you are the subscriber on an active contract and the subscriber on a retired contract, the benefits of the plan covering you as an active employee are primary over the benefits of a plan covering you as a retired employee.
4. If you are the policy holder on two active or retired contracts, the plan that has covered you longer is primary.