Coordination of Benefits Questionnaire

Please complete the following information that will allow us to establish the correct order of financial obligation.

These questions relate to any additional medical or prescription drug coverage you have in addition to IU Health Plans.

Member name:	
Member ID:	**Date of birth (MM/DD/YYYY):**
Do you have group health insurance coverage through your own employer or your spouse or domestic partner's employer? ❑ Yes ❑ No	
If yes, complete the following information:	
Name of insurance carrier:	
Name of policyholder:	
Policy effective date:	**Policy termination date:**
Carrier phone number:	**Policyholder date of birth (MM/DD/YYYY):**
Policy type: ❑ Active ❑ COBRA ❑ Retiree	
I certify that the above information is correct and complete to the best of my knowledge. I understand that I am obligated to provide this information in accordance with my plan. Failure to provide complete and accurate information may result in delay or denial of claim payments. Intentionally providing false information may result in termination of coverage.	
Member signature:	**Date:**

Send the completed form to:
IU Health Plans
950 N. Meridian St., Suite 400
Indianapolis, IN 46204

Or fax to:
F 317.968.1331

IU HEALTH Health Plans