Health Plans

Coordination of Benefits Form

Please complete this form and return it to IU Health Plans so we have a record of additional health insurance coverage you or your dependents and spouse have.

Mail to: IU Health Plans
Attn: COB
950 N. Meridian St., Suite 200
Indianapolis, IN 46204

Spouse and dependent insurance information

Other insurance carrier:	
Address:	Effective date:
	Term date:
	Phone number:
Policy type: ❑ Active ❑ COBRA ❑ Retiree date of retired:	
Policyholder's name:	Policyholder's date of birth:
Covered dependents name	**Relationship**

Adult dependent with employer coverage

Other insurance carrier:		
Carrier's phone number:	Effective date:	Term date:

Medicare coverage

Name on Medicare card:	
Part A (Hospital) effective date:	Part B (Medical) effective date:
Reason for Medicare coverage: ❑ Age 65 or older ❑ Disability ❑ End stage renal disease	
Date dialysis treatment began:	Date of transplant:

Dependents covered by non-custodial parent

Non-custodial parent's name:	Non-custodial parent's date of birth:
Insurance carrier:	
Address:	Effective date:
	Term date:
	Phone number:
Policy type: ❑ Active ❑ COBRA ❑ Retiree date of retired:	

****PLEASE SUBMIT COPY OF DIVORCE DECREE OR COURT ORDER****

Subscriber signature

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.

Signature:	Date: