COORDINATION OF BENEFITS

Please complete all applicable sections below and return this Coordination of Benefits (COB) form as soon as possible to:

PacificSource Health Plans
ATTN: COB Dept.
PO Box 7068
Springfield, OR 97475-0068
Fax (541) 225-3654

If you have any questions about this form, please call our COB Department at (541) 686-1242 x 2685 or toll-free at (800) 624-6052 x 2685.

Group Policy No.	Group Name	PacificSource ID No. (on ID Card), if known

Employee Information

Employee Last Name	First Name	M.I.	Date of Birth
			month________ day______ year____

Other Coverage

Current Other Coverage Information – Do you or any person listed on this application have other dental, vision, or health insurance? ☐No ☐Yes If yes, complete the following.

Name(s)	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Medical ☐Dental ☐Vision ☐Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Medical ☐Dental ☐Vision ☐Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Medical ☐Dental ☐Vision ☐Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Medical ☐Dental ☐Vision ☐Retiree

Medicare – If you or any person on this application have Medicare, is coverage? ☐Part A ☐Part B ☐Part D

Name	Original Effective Date	Medicare No. (include alpha prefix)	Reason for Medicare Entitlement
			☐Age ☐ERSD ☐Disability ☐Dual Entitlement

Declaration

I affirm that the answers given in this application are complete and correct.

____________________________ ________________
Employee Signature **Date**