Affordable Benefit Administrators, Inc.
P.O. Box 10787, Burbank, CA 91510-0787
Ph (800) 350-0148 Fx (818) 842-0225
www.benefitsaba.com

OTHER INSURANCE COVERAGE QUESTIONNAIRE

Your health plan contains a Coordination of Benefits (COB) provision. To ensure that correct benefits are paid on claims for members covered by more than one insurance plan, we need you to complete, sign, date and return this form.

_____ _____
Your name and address Name of Employer

_____ ID Nbr.: _____

_____ Date: _____

1. Do you or any dependents have any other group Medical, Dental or Medicare coverage? ☐ No ☐ Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM BY MAIL OR FAX 1(818) 842-0225.

IF YES, PLEASE COMPLETE THE INFORMATION BELOW.

2. Please list the family members covered by the other policy and the type of coverage you have:

_____ ☐ Medical ☐ Dental ☐ Medicare

_____ ☐ Medical ☐ Dental ☐ Medicare

_____ ☐ Medical ☐ Dental ☐ Medicare

_____ ☐ Medical ☐ Dental ☐ Medicare

For additional family members, attach a separate sheet with the information.

3. Name of other Policyholder: _____ Date of Birth: _____

   Relationship to you: _____

   Name of Employer (if covered thru group plan): _____

   Name of other Insurance Company: _____

   Policy Nbr.: _____ ID Nbr.: _____

   Effective Date: _____ Termination Date: _____

4. If there is a divorce or separation, please name the person responsible for the health care expenses:

   _____

   If there is a divorce decree, please send a copy to us.

   If there is not a divorce / court decree, who has custody of the children? _____

5. Are you actively working?

   Start Date: _____ Last day of active employment: _____

6. Are you or any family member covered by Medicare? ☐ No ☐ Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM BY MAIL OR FAX 1(818) 842-0225.

IF YES, PLEASE COMPLETE THE INFORMATION BELOW.

   Name: _____ Date of Birth: _____

   Medicare Nbr: _____

   Part A Effective Date: _____ Part B Effective Date: _____

Reason for Medicare: ☐ Age ☐ Disability ☐ ESRD (Date of First Dialysis: _____)

Your Signature: _____ Date: _____

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