Oxford Health Plans

Coordination of Benefits Form

Please submit this form with all supporting documentation to Oxford's Coordination of Benefits Department at:

Mailing Address: P.O. Box 7081, Bridgeport, CT 06601-7081 • 203-852-1442 •800-444-6222

SUBSCRIBER INFORMATION (Please Print Clearly Or Type)

Oxford Subscriber Name: _____ Oxford ID Number: _____

Employment Information (Please check the appropriate boxes)

Actively at Work: ❑ Yes ❑ No Total number of employees at company is: ❑ 1-19 ❑ 20-99 ❑ 100+

Retired: ❑ Yes ❑ No Date of Retirement: ___/___/___ Spouse's Social Security Number: _____

Spouse's Name: _____ Spouse's Date of Birth: ___/___/___

Spouse's Current Employer/Company Name: _____

Spouse's Employer Address/Phone Number: _____

COVERAGE INFORMATION

Please Note: If you, your spouse or dependent(s) have:

- Other coverage, please complete Part Al, sign and date the form.
- No other coverage, please complete Part A2, sign and date the form.
- Been divorced/legally separated/single parent, please complete Part B in addition to Part A, sign and date the form.
- Medicare coverage, please complete Part C, sign and date the form.

PART A

1. Other Coverage (List each separately)

Carrier Name: _____

Carrier Address: _____ Telephone #: _____

Subscriber's Name _____ Policy #: _____ Subscriber's SS #: _____

Policy Effective Dates: Start ___/___/___ End ___/___/___ Covered Dependents: _____

Coverage Type: _____

(Check applicable) ❑ Hospital ❑ Major Medical ❑ Prescription ❑ Dental ❑ Retiree ❑ COBRA ❑ Other

Carrier Name: _____

Carrier Address: _____ Telphone #: _____

Subscriber's Name _____ Policy #: _____ Subscriber's SS #: _____

Policy Effective Dates: Start ___/___/___ End ___/___/___ Covered Dependents: _____

Coverage Type: _____

(Check applicable) ❑ Hospital ❑ Major Medical ❑ Prescription ❑ Dental ❑ Retiree ❑ COBRA ❑ Other

If the other coverage is no longer in effect, you must enclose documentation from the former Carrier indicating the date the policy was terminated.

2. No Other Coverage

If your spouse does not have other health coverage, please indicate the reason:

❑ Not married

❑ Benefits not offered ❑ Unemployed ❑ Self employed ❑ Waived, as of: ___/___/___

❑ Part time employee (not eligible for benefits) ❑ Waiting period, eligible for coverage on: ___/___/___

❑ Other, please explain: _____

Please turn over

COVERAGE INFORMATION (Continued)

PART B

Please complete this section if you are divorced, legally separated or a single parent and you have dependent children covered under this plan.

1. Name of other biological parent: _____ Birth Date: ____/____/____
   Does the other biological parent of your dependent children provide health benefits? ❑ Yes ❑ No
   If Yes, please provide the following information:
   Name of other health plan is: _____
   Policy #: _____
   Subscriber's SS #: _____
   Which children are covered? _____

2. Are you divorced or legally separated? ❑ Yes ❑ No Date of divorce/separation: ____/____/____
   Are you a single parent? ❑ Yes ❑ No
   If divorced, check one of the following:
   - ❑ Divorce decree stipulates other parent must provide health benefits
   - ❑ Divorce decree stipulate joint custody
   - ❑ Divorce decree does not stipulate any special provisions
   - ❑ Other, explain: _____

*** A copy of the section of the cour decree pertaining to health coverage or other documents must be provided to support your response.**

PART C

You should complete this section if you, your spouse and/or dependdents are eligible for Medicar e. Please enclose a copy of the Medicare ID Card for each eligible member of you family.

Name of Member eligible for Medicare:

Effective Dates of Medicare:
Part A: ____/____/____ Part B: ____/____/____
Reason for Medicare coverage
(Please check one):
- ❑ Age 65 or older
- ❑ End Stage Renal Failure Disease, (ESRD)

Date Dialysis Treatment Began: ____/____/____
- ❑ Disability, due to: _____

Name of Member eligible for Medicare:

Effective Dates of Medicare:
Part A: ____/____/____ Part B: ____/____/____
Reason for Medicare coverage
(Please check one):
- ❑ Age 65 or older
- ❑ End Stage Renal Failure Disease, (ESRD)

Date Dialysis Treatment Began: ____/____/____
- ❑ Disability, due to: _____

SUBSCRIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information to Oxford in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits. I understand that failure to cooperate with the administration of coordination of benefits can result in the termination of my coverage.

Print Your Name: _____

Signature: _____ Date: _____

Oxford ID Number: _____