



## COORDINATION OF BENEFIT COVERAGE QUESTIONNAIRE

**To fax completed form:** 316-616-6151 • **To call for service:** 866-827-6607

**To mail completed form:** LIFESTYLE HEALTH PLANS • 8300 E. THORN DRIVE STE 300 • WICHITA, KS 67226

The coordination of benefits is the verification of other insurance coverage on yourself and/or your dependents so we can accurately coordinate benefit payments with primary and/or secondary payors for you, based on the rules detailed in the plan. We request this information at least every 12 months. Please provide information regarding any other insurance coverage you currently have.

### EMPLOYER INFORMATION (please print)

Employer name		Group number (and division number, if applicable)			
Employer's street address	City	St	Zip	Phone	

### EMPLOYEE INFORMATION (please print)

First name	Last	MI	Social Security Number	Date of birth	
Street address	City	St	Zip	Phone	Date of hire
Gender <input type="radio"/> Male <input type="radio"/> Female	Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced				
Spouse's name	Spouse's date of birth		Spouse's employer		
Spouse's employer street address	City	St	Zip	Employer's phone	# of children (under 19):

Do you have children residing with you covered by this plan? If so, please provide the following information:

Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth

Does any covered member or dependent have other insurance coverage?     Yes     No    If yes, complete the following:

Does your spouse carry any other insurance coverage through current employer?     Yes     No

If yes please select the type and level of coverage that your spouse carries:

Group Medical	<input type="radio"/> Employee only	<input type="radio"/> Employee & spouse	<input type="radio"/> Employee/family	<input type="radio"/> Employee/child(ren)	<input type="radio"/> No coverage
Dental	<input type="radio"/> Employee only	<input type="radio"/> Employee & spouse	<input type="radio"/> Employee/family	<input type="radio"/> Employee/child(ren)	<input type="radio"/> No coverage
Cancer	<input type="radio"/> Employee only	<input type="radio"/> Employee & spouse	<input type="radio"/> Employee/family	<input type="radio"/> Employee/child(ren)	<input type="radio"/> No coverage
Other	<input type="radio"/> Employee only	<input type="radio"/> Employee & spouse	<input type="radio"/> Employee/family	<input type="radio"/> Employee/child(ren)	<input type="radio"/> No coverage

Are you required by court order to provide insurance for your ex-spouse?     Yes     No

If so, please provide ex-spouse's information:

Ex-spouse's first name	Last	MI	Social Security Number	Date of birth
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Street address	City	St	Zip	Phone	Gender <input type="radio"/> Male <input type="radio"/> Female
Do you have to provide coverage for children resulting from a court order such as divorce? <input type="radio"/> Yes <input type="radio"/> No					
If so, and they do not reside with you for more than 6 months of the year, please provide the following information:					
Child's name				Date of birth	
Child's name				Date of birth	
Child's name				Date of birth	
Child's name				Date of birth	
Which parent was awarded financial responsibility for the medical/dental expenses of the dependent? <input type="radio"/> You <input type="radio"/> Ex <input type="radio"/> Both					
If no court decree was issued, which parent has physical custody of the dependent(s)? <input type="radio"/> You <input type="radio"/> Ex <input type="radio"/> Both					
Is the ex-spouse remarried? <input type="radio"/> Yes <input type="radio"/> No			Does a step-parent carry the dependent(s) under own insurance? <input type="radio"/> Yes <input type="radio"/> No		
If yes, please provide the name and address of the step-parent and their employer and insurance carrier:					
Step-parent's first name		Last		MI	Step-parent's date of birth
Step-parent's employer street address			City	St	Zip
Name of step-parent's carrier					
Insurance carrier's name					Insurance carrier's group number
Insurance carrier's street address			City	St	Zip
Insurance carrier's phone					
Are you or any of your dependents covered under an individual policy not obtained through an employer? <input type="radio"/> Yes <input type="radio"/> No					
If so, please provide carrier's contact information below:					
Insurance carrier's name					Insurance carrier's group number
Insurance carrier's street address			City	St	Zip
Insurance carrier's phone					
Are you or any of your dependents eligible for Medicare? <input type="radio"/> Yes <input type="radio"/> No					
If so, please list those with Medicare coverage:					
Effective Date of Medicare Part A: ____/____/____				Effective Date of Medicare Part B: ____/____/____	
If you or your family member have Medicare and are under the age of 65, please indicate the reason for eligibility					
I confirm the above information is accurate and current:					
Employee signature					Date

Thank you. Please notify us if this information changes within the next 12 months, including any change of address. Use the contact information at the top of this form if you have questions.