UNIFIED GROUP SERVICES
Coordination of Benefits - Other Insurance Questionnaire

Employee Name: _____ **Employee ID#:** _____ **Group #** _____

1. Do you or any member of your family on your employer's plan carry coverage through another benefit plan with a different company (including Medicare)? _____ Yes _____ No

2. **If you answered "No" to the above question:**
   a. Does your spouse's employer offer any plan coverage for Medical, Dental, Vision, and Rx (whether you elect it or not)? ____Yes ____No
   b. Please sign, date, and return to Unified Group Services or HR.

3. **If you answered "Yes" to question #1 or #2a, please complete sections "a" through "d" regarding your other insurance:**

   a. Select Coverage type(s) that applies ____ Medical ____ Dental ____ Vision _____ Rx

   b. List the names of those individuals covered by another benefit plan:

Name	Date of Birth	Relationship	Coverage Type(s)

   c. Name of Insured: _____

   Date of Birth: _____ Social Security #: _____
   Employer, Union or Sponsoring Organization of Insured: _____
   Effective Date: _____ Employment Status: _____ Active _____ Retired
   If Retired, Retirement Date: _____
   Employer's Street Address: _____
   Employer's City, State & Zip: _____
   Benefit Plan's Name: _____ Plan # _____
   Benefit Plan's Street Address: _____
   Benefit Plan's City, State & Zip: _____
   Benefit Plan's Phone Number: _____

   d. Are the parents of any of the dependent children on this policy either divorced or separated?
   _____ Yes _____ No

   Name of Dependent(s): _____
   1. Name of Custodial Parent: _____
   2. Is there a specific parent that is court ordered to maintain healthcare benefits? __ Yes __ No
      If yes, please attach the appropriate section(s) of the court order

4. Do you or any of your family have Medicare Part A or Part B coverage? _____ Yes _____ No
   If yes, please complete the following information

   Policyholder's Name & Relationship: _____
   Medicare Policy #: _____ Effective Date: Part A _____ Part B _____
   Reason for Medicare Eligibility/Entitlement:
   _____ Age ____ Disability ____ End Stage Renal Disease (ESRD)
   ____ Disability and Current ESRD ____ Onset Date of ESRD

I hereby certify that the above statements are true and correct to the best of my knowledge, and authorize any health plan, employer, or hospital to release all information with respect to myself and any of my dependents which may affect the benefits under this or any other plan providing benefits or services.

Employee Signature: _____ **Date:** _____

Unified Group Services, Inc.

"We take care of the customer...and then some!"

Dear Plan Participant:

We need to determine if you and/or your family members are covered by another health plan. Please complete the form on the back of this letter and return it to:

Unified Group Services
P.O. Box 10
Pendleton, IN 46064-0010

Since this information is required to avoid unnecessary delays in claims payments, it would be beneficial if you would return the completed form within ten (10) days of receiving it. Even though you may have supplied us with this information in the past, we are required to update all benefit information at the beginning of each calendar year. Thank you.

Sincerely,

Claims Account Manager

P. O. Box 10 • Pendleton, IN • 46064-0010 • Phone (765) 608-6680 • Toll Free (800) 291-5837 • Fax (765) 608-6689