Coordination of Benefits Form

Health Net Health Plan of Oregon, Inc.

Member name: ______________________________ Date of birth: ___/___/___

Section 1 – Employment status

Are you or your spouse actively working? (If "Yes," please complete the employment information.)

Policyholder: ☐ No ☐ Yes Employer:______________________ Phone #: (______)______________

Spouse: ☐ No ☐ Yes Employer:______________________ Phone #: (______)______________

Have you or your spouse retired? (If "Yes," please complete the retirement date and former employer information.)

Policyholder: ☐ No ☐ Yes Retirement date: ___/___/___ Employer: ___/___/___ Phone #: (______)______________

Spouse: ☐ No ☐ Yes Retirement date: ___/___/___ Employer: ___/___/___ Phone #: (______)______________

Are you, your spouse or dependent(s) covered under COBRA?

Policyholder: ☐ No ☐ Yes Effective date: ___/___/___ Termination date: ___/___/___

Spouse: ☐ No ☐ Yes Effective date: ___/___/___ Termination date: ___/___/___

Dependent: ☐ No ☐ Yes Effective date: ___/___/___ Termination date: ___/___/___

Have you, your spouse or dependent(s) received Long Term Disability benefits?

Policyholder: ☐ No ☐ Yes Effective date: ___/___/___

Spouse: ☐ No ☐ Yes Effective date: ___/___/___

Dependent: ☐ No ☐ Yes Effective date: ___/___/___

Section 2 – Other health insurance

Are you, your spouse or dependent(s) covered by another health insurance plan?

Policyholder: ☐ No ☐ Yes (If "Yes," refer to the other insurance card to complete this section.)

Spouse: ☐ No ☐ Yes (If "Yes," refer to the other insurance card to complete this section.)

Dependent: ☐ No ☐ Yes (If "Yes," refer to the other insurance card to complete this section.)

(A) Other cardholder: ______________________ Date of birth: ___/___/___ Social Security #: ____ – ___ – ______

(B) Other health insurance plan:______________________ Phone #: (______)______________

Group #:______________________ Member ID #: ______________________

Effective date: ___/___/___ Termination date: ___/___/___

(C) Other prescription plan:______________________ Phone #: (______)______________

Group #:______________________ Member ID #: ______________________

Effective date: ___/___/___ Termination date: ___/___/___

(D) List all persons covered by the health insurance plan listed above.

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Are you, your spouse or dependent(s) covered by any health insurance plan listed above?

☐ No ☐ Yes (If "Yes," please attach a copy of the other insurance card(s) with your response.)

(continued)

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Section 3 – Medicare

Have you, your spouse or dependent(s) applied for social security benefits as a result of a disability?

Policyholder: ☐ No ☐ Yes Effective date of disability benefit: ___/___/___

Spouse: ☐ No ☐ Yes Effective date of disability benefit: ___/___/___

Dependent: ☐ No ☐ Yes Effective date of disability benefit: ___/___/___

Are you, your spouse or dependent(s) covered by Medicare?

Policyholder: ☐ No ☐ Yes (If "Yes," refer to your Medicare card to complete this section.)

Spouse: ☐ No ☐ Yes (If "Yes," refer to your Medicare card to complete this section.)

Dependent: ☐ No ☐ Yes (If "Yes," refer to your Medicare card to complete this section.)

Cardholder name:	Medicare ID #:	Effective dates:	Medicare entitlement reason – Check one:
		Part A: ___/___/___ Part B: ___/___/___	☐ Age ☐ Disability ☐ ALS ☐ Kidney failure
		Part A: ___/___/___ Part B: ___/___/___	☐ Age ☐ Disability ☐ ALS ☐ Kidney failure

Section 4 – Authorization

Name of person completing this form (please print): ____________________

I certify that the above information is true and correct to the best of my knowledge.

Signature: ____________________ Phone #: (______)____________________ Date: ___/___/___

Email address: ____________________