Coordination of Benefits Form

Policy Holder Name: ______________________________

Policy Holder Date of Birth: _________________________

Employer Name & Subscriber ID number: ________________________________

1. **Do you or any of your enrolled dependents have other coverage?**

   Yes_________ No_________

   If yes, please check all coverages that apply: _____Medical _____Dental

2. **Please list all dependents who are covered:**

   ________________ ________________ ________________

   ________________ ________________ ________________

3. **Name of Insurance Company:_____________________________________**
4. **Phone number (including area code):_______________________________**
5. **Name of Policy Holder:____**
6. **Policy Holders Date of Birth:_______________________________________**
7. **Policy Holders ID and/or Social Security Number: _____________________**
8. **Effective Date of Other Coverage:__________________________________**
9. **Termination date of other coverage (if no longer active):_______________**

Signature________________________ Date:________________

HealthEZ Claims Department

Return form to COBLetters@HealthEZcom or fax to 952-896-4888