Coordination of Benefits

Please complete all applicable sections below and return this form as soon as possible to:

PacificSource Health Plans, ATTN: COB Dept.
PO Box 7068, Springfield, OR 97475-0068
Fax 541-225-3654
[Secure] COB@PacificSource.com

Questions? Please call our COB team at **800-624-6052**, TTY: 711. We accept all relay calls.

Group policy number __________ Group name ________ PacificSource ID number, if known (on ID card) __________

Employee information

Employee last name ______________________ First name ______________ MI ____ Date of birth _____/_____/_____

Other coverage

Current other coverage information – Do you or any person listed on this application have other dental, vision, or health insurance? Yes No If yes, complete the following.

Name(s)	Insurance carrier	Date of coverage	Will coverage continue?	Type of coverage
	Carrier name:	Begin:	Yes	Medical
	Policy number:			Dental
	Phone number:	End:	No	Vision
				Retiree
	Carrier name:	Begin:	Yes	Medical
	Policy number:			Dental
	Phone number:	End:	No	Vision
				Retiree
	Carrier name:	Begin:	Yes	Medical
	Policy number:			Dental
	Phone number:	End:	No	Vision
				Retiree
	Carrier name:	Begin:	Yes	Medical
	Policy number:			Dental
	Phone number:	End:	No	Vision
				Retiree

Medicare

If you or any person on this application have Medicare, indicate the type(s) of coverage: Part A Part B Part D

Name ____________________________ Original effective date ____/____/____ Medicare number ________________

Reason for Medicare eligibility: Age ESRD Disability Dual eligibility

Medicaid

Name ____________________________ Original effective date ____/____/____ Medicaid ID number ______________

Declaration

I affirm that the answers given in this application are complete and correct.

Employee signature ____ Date __________________________