Coordination of Benefits

PacificSource HEALTH PLANS

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

If you have any questions about this form, please call our COB team at **800-624-6052**, ext. 2685, TTY 711.

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, is 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 ____________________