McLaren HEALTH PLAN

Coordination of Benefits Form

SECTION 1: OTHER GROUP HEALTH COVERAGE				
Are you or any of your covered dependents also covered by another group health plan?	Yes ☐	No ☐		
Another group health plan is defined as one that is generally an employer provided health plan though the employee may be sharing costs. Medicare is not an employer provided health plan. However, if you have Medicare, indicate **NO**, but complete section 5.				

SECTION 2: OTHER GROUP HEALTH CARE PLAN OR PROGRAM INFORMATION (If Medicare, go to Section 5)				
Employer	Street Address	City	State	Zip Code
Insurance Company	Street Address	City	State	Zip Code
Contract Number	Policy Number	Effective Date	Cancellation Date	
Name of Subscriber	Sex ☐M ☐F	Relationship to Subscriber	Birth Date	

Type of Coverage	Type of Plan (check all that apply)			
Single ☐	Hospital ☐	Surgical/Medical ☐	Prescription Drug ☐	
Two Person ☐	Vision ☐	Hearing ☐	Dental ☐	
Family ☐	Other ☐	(please describe): _____		

SECTION 3: DEPENDENT INFORMATION

Members (other than Subscriber above) covered under the contract above. If there are more than five, list them on the other side.

Name	Self	Spouse	Child	Birth Date
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

SECTION 4: DIVORCE/CUSTODY INFORMATION

Fill out this section **only** if you have children and/or step-children covered by other health care coverage through court order (i.e. divorce, separation, etc.) List the covered children below. If there are more than three, list them on the other side.

Name	Responsible Parent			
	Father	Mother	Other	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
If no court order exists, which parent has custody?	☐	☐	☐	

Name of Insured Person for Child's Coverage (First & Last)				Birth Date
Employer	Street Address	City	State	Zip Code
Insurance Company	Street Address	City	State	Zip Code
Group Policy Number:	Effective Date:	Cancellation Date:		

SECTION 5: MEDICARE INFORMATION

Name of Member Covered by Medicare (self)		Name of Member Covered by Medicare (spouse if applicable	
Medicare ID Number	Sex M F	Medicare ID Number	Sex M F
Effective Date of Medicare Part A: _____ Part B: _____ Part D: _____		Effective Date of Medicare Part A: _____ Part B: _____ Part D: _____	

Please return this form to McLaren Health Plan/Health Advantage Recovery Department:
P.O. Box 1511, Flint MI 48501-1511 Or Fax to (810) 733-9652

MHP20170929

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