Health Net®

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: _____