Health Net Health Plan of Oregon, Inc., "Health Net"

Coordination of Benefits Form

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: _____ D ate of birth: _____ Social Security #: _____
(B) Other health insurance plan: _____ Phone #: _____
Group #: _____Member ID #: _____
Effective date: _____Member ID#: _____
(C) Other prescription plan: _____ Phone #: _____
Group #: _____Member ID #: _____
Effective date: _____T ermination 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.)

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 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.)

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: _____