COORDINATION OF BENEFITS (COB) FORM

Request for Other Coverage Information

PEEHIP

This form is a request for other coverage information we must have in order to update your insurance information and provide proper coverage.

INSTRUCTIONS: Print clearly in black ink. Complete the form in full, sign, and return it to PEEHIP using **one** of the following methods:

Online: https://mso.rsa-al.gov/ (*the fastest, preferred method*)

Mail: PEEHIP, P.O. Box 302150, Montgomery, AL 36130

If you, your spouse and/or dependent children are covered under PEEHIP and have any other insurance coverage, **EXCLUDING MEDICARE AND PEEHIP**, please indicate the other coverage on this form or **online** at https://mso.rsa-al.gov. Failure to timely submit this form will result in your account being placed on claim hold and may cause a denial of medical and prescription claims.

SECTION A. PEEHIP SUBSCRIBER INFORMATION

SSN/PID	First and Last Name	Telephone Number	Cell Phone Number	Email Address

SECTION B. OTHER INSURANCE COVERAGE INFORMATION, EXCLUDING MEDICARE AND PEEHIP (Check all that apply)

☐ Yes ☐ No - I have/had other insurance coverage while covered by PEEHIP.

☐ Yes ☐ No - My spouse has/had other insurance coverage while covered by PEEHIP.

☐ Yes ☐ No - My dependent child(ren) has/had other insurance coverage provided by my spouse and/or other insurer while covered by PEEHIP.

If you answered "Yes" to any of the above, you must complete the Insurance Company information below.
If you answered "No" to all of the above, skip to Section C.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)

Name of Policy Holder	Date of Birth	Contract/Policy Number	Effective Date of Coverage	Insurance Co. Phone No.

Name of Insurance Company (check one)	Coverage Provided Through	Type(s) of coverage (check all that apply)
☐ Aetna ☐ Blue Cross Blue Shield ☐ Cigna ☐ Tricare ☐ UnitedHealthcare ☐ VA ☐ SEIB/Local Govt. ☐ Other:____________	☐ Employer Group ☐ Retiree Group ☐ Marketplace ☐ Other	☐ Hospital/Medical with Prescription Drug ☐ Dental ☐ Hospital/Medical without Prescription Drug ☐ Vision ☐ Prescription Drug Only ***Note:*** *HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Drug Coverage*

Are you or any of your PEEHIP dependents covered as **dependents** on this insurance policy? ☐ Yes-- ▸ *List each dependent below* ☐ No

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for healthcare expenses? (check first that applies)** **Copy of Divorce Decree Required**
		☐ Spouse ☐ Child--- ▸ ☐ Stepchild------------------------------ ▸	☐ Yes ☐ No----------------- ▸	☐ You (PEEHIP Subscriber) or Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree
		☐ Spouse ☐ Child--- ▸ ☐ Stepchild------------------------------ ▸	☐ Yes ☐ No----------------- ▸	☐ You (PEEHIP Subscriber) or Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree
		☐ Spouse ☐ Child--- ▸ ☐ Stepchild------------------------------ ▸	☐ Yes ☐ No----------------- ▸	☐ You (PEEHIP Subscriber) or Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree

SEE REVERSE SIDE – THIS FORM CONTAINS MORE INFORMATION

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)				
Name of Policy Holder	Date of Birth	Contract/Policy Number	Effective Date of Coverage	Insurance Co. Phone No.

Name of Insurance Company (check one)	Coverage Provided Through	Type(s) of coverage (check all that apply)
☐ Aetna ☐ Blue Cross Blue Shield ☐ Cigna ☐ Tricare ☐ UnitedHealthcare ☐ VA ☐ SEIB/Local Govt. ☐ Other: ____________	☐ Employer Group ☐ Retiree Group ☐ Marketplace ☐ Other	☐ Hospital/Medical with Prescription Drug ☐ Dental ☐ Hospital/Medical without Prescription Drug ☐ Vision ☐ Prescription Drug Only *Note: HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Drug Coverage*

Are you or any of your PEEHIP dependents covered as **dependents** on this insurance policy? ☐ Yes--- ▸ *List each dependent below* ☐ No

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for healthcare expenses? (check first that applies)** **Copy of Divorce Decree Required**
		☐ Spouse ☐ Child--- ▸ ☐ Stepchild------------------------------ ▸	☐ Yes ☐ No----------------- ▸	☐ You (PEEHIP Subscriber) or Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree
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Action Required: If you have indicated that you, your spouse, or your dependent child is insured under another Insurance Plan, you are required to provide a copy of the front and back of the insurance card for each card.

****If applicable, you must provide a copy of the section of the Court Order/Divorce Decree pertaining to health coverage or other documents to support your response.**

SECTION C. SUBSCRIBER CERTIFICATION

Statement: Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. It is fraudulent to submit information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse PEEHIP for any money it was induced to pay as a result of the information I provided. Receipt and/or completion of this form is not a guarantee of eligibility. I further authorize the release of any pertinent information from any source available to PEEHIP to verify the status of my employment.

Subscriber Signature **Date Signed**

HELPING YOU UNDERSTAND WHY THE INFORMATION IS NEEDED

COORDINATION OF BENEFITS. WHAT IS IT? Coordination of Benefits is designed to keep your rates as low as possible by eliminating excess payments. It keeps the cost of your medical care down without affecting the way you receive care. Oftentimes, members and their dependents are covered by two insurance plans. Working spouses cover each other and children are often covered on both parents' plans. When a PEEHIP member is covered by more than one health plan, the payment of his/her benefits is coordinated between the two plans.

HOW COORDINATION WORKS. If you have more than one plan and you receive services or supplies that are covered under both plans, this is how your benefits are coordinated:

The primary plan pays the full extent of its benefits. PEEHIP uses the first of the following rules that applies:

1. The benefits of the plan that covers you as an employee will be paid before the plan that covers you as a dependent. However, if you are eligible for Medicare coverage and Medicare is primary to your plan and your spouse has active coverage through an employer, then your plan pays third.
2. For claims on dependent children, the benefits of the parent's plan whose birthday falls earlier in the calendar year will be primary (this is known as the birthday rule) unless the parents are separated or divorced, in which case:
   a. If a court decree specifies one parent cover the child's medical care, that parent's plan is primary.
   b. If there is no court decree specifying coverage, the plan covering the parent with custody will be primary.
   c. However, if the parent with custody remarries, the plan covering that parent will be primary, the plan covering the step-parent will be secondary, and the plan covering the parent without custody will be third.
   d. If a court decree specifies joint custody but does not say which parent covers the child's medical care, then the birthday rule is used.
3. If you are the subscriber on an active contract and the subscriber on a retired contract, the benefits of the plan covering you as an active employee are primary over the benefits of a plan covering you as a retired employee.
4. If you are the policy holder on two active or retired contracts, the plan that has covered you longer is primary.