PEEHIP
OF ALABAMA

Coordination of Benefits (COB) Form

Public Education Employees' Health Insurance Plan
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___ **PID** ____________

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

If you, your spouse, and/or dependent children are covered under PEEHIP and have any other insurance coverage, EXCLUDING MEDICARE AND PEEHIP, please indicate on form.

Name ______________________________
First Middle/Maiden Last

Mailing Address ______________________________
Street or P.O. Box Apt.# City State ZIP Code

Telephone ______________________________
Cell Phone Home Phone Work Phone

Date of Birth ____________ Email Address ____________

Section B
Other Insurance Coverage Information

Excludes Medicare and PEEHIP

Check all that apply:

1. I have/had other insurance coverage while covered by PEEHIP. ❑ Yes ❑ No
2. My spouse has/had other insurance coverage while covered by PEEHIP. ❑ Yes ❑ No
3. My dependent child(ren) has/had other insurance coverage provided by my spouse and/or other insurer while covered by PEEHIP. ❑ Yes ❑ No

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 D.

Section C
Insurance Company Information

List each insurance company separately. Attach additional sheet(s) if needed.

Name of Policyholder ______________________________
Please Print

Contract/Policy Number ____________ Effective Date of Coverage ____________

Telephone ____________ Date of Birth ____________
Insurance Company Telephone

Name of insurance company (check one) ❑ Aetna ❑ Blue Cross Blue Shield ❑ Cigna ❑ Tricare ❑ UnitedHealthcare ❑ VA ❑ SEIB/Local Govt. ❑ Other ____________

Coverage provided through ❑ Employer Group ❑ Retiree Group ❑ Marketplace ❑ Other

Types of coverage (check all that apply) ❑ Dental ❑ Vision ❑ Prescription Drug Only ❑ Hospital/Medical with Prescription Drug ❑ Hospital/Medical without Prescription Drug
HSA, HDHP, and HRA plans are considered Hospital/Medical with Prescription Drug Coverage

Are you or any of your PEEHIP dependents covered as <u>dependents</u> on this insurance policy? ❑ Yes (List each dependent below) No ❑

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policyholder	Are both parents married or living together?	Based on court decree, who is responsible for healthcare expenses? (check <u>first</u> that applies)** Copy of divorce decree required
		❑ Spouse ❑ Child → ❑ Stepchild →	❑ Yes ❑ No →	❑ You (PEEHIP Subscriber) or Spouse is responsible ❑ Policyholder or their Spouse is responsible ❑ You (PEEHIP Subscriber) or your Spouse has custody ❑ Policyholder or their Spouse has custody ❑ Joint custody or no court decree
		❑ Spouse ❑ Child → ❑ Stepchild →	❑ Yes ❑ No →	❑ You (PEEHIP Subscriber) or Spouse is responsible ❑ Policyholder or their Spouse is responsible ❑ You (PEEHIP Subscriber) or your Spouse has custody ❑ Policyholder or their Spouse has custody ❑ Joint custody or no court decree
		❑ Spouse ❑ Child → ❑ Stepchild →	❑ Yes ❑ No →	❑ You (PEEHIP Subscriber) or Spouse is responsible ❑ Policyholder or their Spouse is responsible ❑ You (PEEHIP Subscriber) or your Spouse has custody ❑ Policyholder or their Spouse has custody ❑ Joint custody or no court decree

This form should be completed, signed, dated, and returned via mail or <u>https://mso.rsa-al.gov</u>.

Coordination of Benefits (COB) Form

Name ____________________ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

Section C
Insurance Company Information

Section continued from page 1

Name of Policyholder ____________________
Please Print

Contract/Policy Number ____________________ Effective Date of Coverage ____________________

Telephone ____________________ Date of Birth ____________________
Insurance Company Telephone

Name of insurance company (check one) ❑ Aetna ❑ Blue Cross Blue Shield ❑ Cigna ❑ Tricare ❑ UnitedHealthcare ❑ VA ❑ SEIB/Local Govt. ❑ Other ____________________

Coverage provided through ❑ Employer Group ❑ Retiree Group ❑ Marketplace ❑ Other

Types of coverage (check all that apply) ❑ Dental ❑ Vision ❑ Prescription Drug Only ❑ Hospital/Medical with Prescription Drug ❑ Hospital/Medical without Prescription Drug
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 Policyholder	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 ❑ Policyholder or their Spouse is responsible ❑ You (PEEHIP Subscriber) or your Spouse has custody ❑ Policyholder or their Spouse has custody ❑ Joint custody or no court decree
		❑ Spouse ❑ Child → ❑ Stepchild →	❑ Yes ❑ No →	❑ You (PEEHIP Subscriber) or Spouse is responsible ❑ Policyholder or their Spouse is responsible ❑ You (PEEHIP Subscriber) or your Spouse has custody ❑ Policyholder or their Spouse has custody ❑ Joint custody or no court decree
		❑ Spouse ❑ Child → ❑ Stepchild →	❑ Yes ❑ No →	❑ You (PEEHIP Subscriber) or Spouse is responsible ❑ Policyholder or their Spouse is responsible ❑ You (PEEHIP Subscriber) or your Spouse has custody ❑ Policyholder or their Spouse has custody ❑ Joint custody or no court decree

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 D
Subscriber Certification

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.

Sign Here* ➔ *Subscriber **Signature** ____________________ **Date** ____________________

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.

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 their benefits is coordinated between the two plans. 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. 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. 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 policyholder on two active or retired contracts, the plan that has covered you longer is primary.