Other coverage information

Please complete and return this form. For your claims to be processed timely, this Coordination of Benefits (COB) form is required **if you or dependents on your policy** have coverage through another medical health insurance plan.

Name:	**Member ID** (Personnel #):
Address:	**City, State, ZIP:**

Marital Status:

☐ Never Married ☐ Married ☐ Single ☐ Separated ☐ Divorced

Please check the reason(s) for submitting this form:

☐ No other insurance ☐ Add other insurance

Section A - Other medical health insurance

Please complete this section if you, your spouse, or dependents have coverage other than this plan.

First name	Last name	Relationship	Effective date	Termination date	Reside in same household?

Insurance carrier name:	**Phone:**
Insurance carrier address:	**Insurance carrier city, state, ZIP:**

Policyholder name:	**Policyholder ID#:**	**Date of birth** (mm/dd/yyyy)**:**
Policyholder address:	**Policyholder city, state, ZIP:**	

Section B - Dependent children of separated/divorced parents

Please complete this section for any dependent child(ren) listed in Section A whose parents are divorced, legally separated, or who have some other legal reason for providing coverage.

First name	Last name	Relationship	Other insurance carrier	Policy ID#	Effective date	Termination date

Other insurance policyholder name:

Date of birth (mm/dd/yyyy)**:**

Other insurance responsible due to:

☐ Custody ☐ Divorce decree ☐ Child support order

If any of these boxes are checked, please enclose a copy of the complete document that establishes financial responsibility for medical care.

Section C - Medicare

Please complete this section if you or someone on your policy also has Medicare.

First name	Last name	HIC#	Begin date	End date
			Part A	
			Part B	
			Reason ☐ 65+ ☐ Disability ☐ ESRD	
First name	**Last name**	**HIC#**	**Begin date**	**End date**
			Part A	
			Part B	
			Reason ☐ 65+ ☐ Disability ☐ ESRD	
First name	**Last name**	**HIC#**	**Begin date**	**End date**
			Part A	
			Part B	
			Reason ☐ 65+ ☐ Disability ☐ ESRD	

Section D - Signature

I certify that the information provided on this form is true, complete and correct.

Policyholder signature:

Date (mm/dd/yyyy)**:**

You may submit the information in one of the following ways:

- Email: TysonMembership@arkbluecross.com
- Fax: **501-378-2379**

If you have any questions, please contact Customer Service at **1-800-452-6199**.