COORDINATION OF BENEFITS

When you're insured by more than one health plan, it's important to let us know. That way we can determine what portion of your claims Medica should pay and what portion your other plan should pay. This is called "coordination of benefits." To provide us the needed information, please complete the form below and have the policyholder sign at the bottom. The policyholder is the person who is enrolled in the additional health plan.

- If you have more than one additional plan, you can make a copy of this form or download another one at **Medica.com/MemberForms**.
- If a divorce decree or court order requires insurance to be provided to minor children, please include a copy of the relevant sections of the decree or order. Sections include: page(s) identifying the petitioner and respondent, page(s) identifying the child/children and page(s) outlining the provision of insurance coverage.
- Medica and other health plans have rules that determine which plan will pay benefits first. For more information, see your coverage document, available on **Medica.com/SignIn**.
- When you receive care, please let providers know about all of your health insurance coverage. In some cases they may ask you to file claims with your other health plan. Ultimately, it is the policyholder's responsibility to ensure that the other health plan has all the information needed to process a claim.
- If you're notified of a claim payment by your other health plan, please call Medica Customer Service to find out how to submit a copy of your Explanation of Benefits statement.

If you have any questions, call Customer Service at the number on the back of your Medica ID card. If your coverage information changes in the future, please contact Customer Service.

Mail completed forms to:

Medica Claims
P.O. Box 30990
Salt Lake City, UT 84130-9882

Coverage Type:

☐ Medical ☐ Dental (If both, please write dental information on a separate piece of paper and attach)

Medica enrollee's name_____ Spouse's name _____

Medica enrollee's member number_____

POLICY INFORMATION

Name of **other** insurance company (**not** Medica)_____

Phone number of other insurance company (likely on your ID card)_____

Policy or group no. _____ Subscriber or ID no. _____

Name of policyholder _____ Date of birth _____

Effective date of policy _____ Policy end date _____

Other family members covered (list names)_____

How was this insurance purchased? ☐ Through the policyholder's employer
☐ As an individual (premiums are paid directly to the insurance company)
☐ Other_____

Where are the insurance claims submitted? (e.g., to the employer or insurance company)

Name of company _____

Street address _____

City _____ State _____ ZIP _____

I authorize the insurance company named above to release to Medica information regarding my claims for coverage under current policies issued by both companies. I understand that the purpose of this release of information is to ensure appropriate coordination of benefits due to me under both certificates. I further understand that copies of this authorization shall be as valid as originals. This authorization will automatically expire one year following the date of signature without my express revocation.

Signed _____ Date _____

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