



MONTANA ASSOCIATION OF COUNTIES

PO BOX 1966

MISSOULA MT 59806-1966

Phone# (888) 883-3233

Fax# (406)523-3111

To: _____

Group ID: _____
Group Name: _____
Participant: _____
Participant ID #: XXX-XX-_____
Claimant: _____
Charge: _____
Date of Service: _____
Claim # if known: _____

Dear _____,

We have received information that there may be other insurance coverage on the above claimant. Please complete the following questionnaire and return it to the address above. Pursuant to the claims processing policy adopted by the plan, we must receive this information within 45 days of the date of this letter or the claim will be denied. If you have questions please contact our customer service department. Thank you in advance for your prompt attention to this request.

COORDINATION OF BENEFITS

Do you or any other family member have other insurance coverage? ___Yes ___No

If yes, please complete the following:

Names of family members who have other coverage:

Name Date of Birth Name Date of Birth

Name Date of Birth Name Date of Birth

Name Date of Birth Name Date of Birth

Name of other insurance coverage _____

Address _____

City, State, Zip _____

Phone Number _____ Group Number _____

Name of Policy Holder _____ Policy Number _____

Effective Date of Coverage _____ Social Security Number _____

Address of Policy Holder _____

City, State, Zip _____

Participant: _____ Participant ID #: _____

Group Name: _____ Group ID #: _____

Claimant: _____ Date of Service: _____

Type of coverage: Medical Dental Vision Life Auto Pharmacy Disability

Please read the following statement and answer any questions below which are applicable.

When parents of a dependent child are divorced or separated, or in the case of a single parent, the coverage of the parent with custody of the child normally pays first unless there is a court order which says the other parent is responsible for the child's expenses. In order to determine which coverage has primary liability on the above child/children, please complete the following:

What was the date of the divorce or separation? _____

Which parent has physical custody of the child? _____

Is there a court order making one parent responsible for the child's medical/dental/vision expenses?

Yes No

***IF YES, PLEASE PROVIDE A COPY WITH THIS FORM.

***IF YES, WHAT WAS THE EFFECTIVE DATE OF COVERAGE? _____

Has the parent with custody remarried? Yes No

If yes, does the step-parent cover this child? Yes No

I certify that the above information is true to the best of my knowledge. I authorize any physician, facility, insurance company, or employer to release information to the Plan Supervisor/Claims Processor.

Signature of Employee

Date

Signature of Dependent (if over 18 years of age)

Date

Printed Name of Person Signing Form

Some states require that we notify you "Any person who knowingly with intent to defraud, or deceive an insurance company or employee benefit plan, files a false statement containing false, incomplete, or misleading information is guilty of a felony of third degree."