Coordination of Benefits Questionnaire

Important. Your Immediate Response is Required.

You have been identified as an employee who is enrolled in a Dignity Health medical plan with a covered dependent for whom we need to verify other medical coverage. Your response is required. We are collecting the following information to verify if your dependent(s) have any other medical coverage. **Please respond even if your covered dependent(s) have no other insurance.**

Update the other insurance information by doing one of the following:

- ❑ Log on to www.brmsonline.com/dignityhealth and then click on *MyHealthBenefits.com* located on the home page. If you have already registered as a plan member, you may log on and complete the online Coordination of Benefits Questionnaire. If you have not registered as a plan member, choose *Create a New Account* and follow the instructions.
- ❑ Call the number on your ID card to speak with a BRMS representative.
- ❑ Fax this completed form to BRMS via secure fax: 916.467.1419.
- ❑ Mail this completed form to BRMS, Attention COB Department, PO Box 2140, Folsom, CA 95763.

1. Do your family members have other medical insurance coverage with another company, or through Medicare?

   ☐ No ☐ Yes

   If you answered 'no' you may skip to #4.
   If you answered 'yes' to the above question, please continue with additional questions.

2. Is the other coverage through Medicare, Medi-Cal or another public health insurance program?

   ☐ No ☐ Yes

   If you answered 'no' you may skip to #4.
   If you answered 'yes' to the above question, please continue with additional questions.

3. If your covered dependent(s) have medical coverage with another company, please complete the following information. (*If you require additional space, use the reverse side of this form.)*

   ☐ Name(s) of dependent(s) with other insurance coverage: _____

   ☐ Plan holder Name & Insurance Company Name: _____

   _____

   ☐ Other Insurance Holder's DOB: _____

   ☐ Medical Plan Number: _____ Coverage Type: ☐ Family ☐ Single

4. **I hereby certify all information given by me is accurate and true.**

_____	_____
Print Employee Name	Medical Plan ID #
_____	_____
Employee Signature	Date

Failure to provide the requested information may cause your dependent's claims to be denied.
Additional Dependents with Other Coverage:

Dependent #2

- ☐ Name(s) of dependent(s) with other insurance coverage: _____
- ☐ Plan holder Name & Insurance Company Name: _____
- ☐ Other Insurance Holder's DOB: _____
- ☐ Medical Plan Number: _____ Coverage Type: ☐ Family ☐ Single
- ☐ Medicare HIC Number: _____

Dependent #3

- ☐ Name(s) of dependent(s) with other insurance coverage: _____
- ☐ Plan holder Name & Insurance Company Name: _____
- ☐ Other Insurance Holder's DOB: _____
- ☐ Medical Plan Number: _____ Coverage Type: ☐ Family ☐ Single
- ☐ Medicare HIC Number: _____

Dependent #4

- ☐ Name(s) of dependent(s) with other insurance coverage: _____
- ☐ Plan holder Name & Insurance Company Name: _____
- ☐ Other Insurance Holder's DOB: _____
- ☐ Medical Plan Number: _____ Coverage Type: ☐ Family ☐ Single
- ☐ Medicare HIC Number: _____

Dependent #5

- ☐ Name(s) of dependent(s) with other insurance coverage: _____
- ☐ Plan holder Name & Insurance Company Name: _____
- ☐ Other Insurance Holder's DOB: _____
- ☐ Medical Plan Number: _____ Coverage Type: ☐ Family ☐ Single
- ☐ Medicare HIC Number: _____