



Date

Name

Address

City, State, Zip

**RE: *Attached Coordination of Other Health Benefits Form***

Dear:

Claims have been received in our office for you or one of your dependents. Our underwriting guidelines require us to verify the possibility of any other coverage. Please complete the enclosed *Coordination with Other Health Benefit Plans* form and return to our office within 2 weeks of this letter to avoid any processing delays with your claim. ***Your claim cannot be processed until the requested information is received.*** Please note, the sooner this form is received in our office, the sooner your claim will be processed. To avoid receiving additional forms for these services, please return this form as soon as possible. Please disregard this request if you have previously returned a questionnaire related to this service to our office.

Please be sure to complete this form for you and all listed dependents on your policy. If changes occur, it is your responsibility to notify Northern Illinois Health Plan immediately.

If you have any questions regarding the above request or the completion of this form, please call our office at (815) 599-7050 or the toll free number (800) 723-0202. Thank you for your prompt assistance in this matter.

Thank you,

Enrollment Department  
Northern Illinois Health Plan

Enc.

# COORDINATION WITH OTHER HEALTH BENEFIT PLANS

Employer Name: Boone County		Group #: 6525		
<b>SECTION I —EMPLOYEE INFORMATION</b>				
Employee Name:		Employee Home Address:		
Employee ID Number:	Employee Birth date:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Legally Separated		
Please indicate whether you or any of your dependents are covered by any other health coverage:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate if your spouse or dependents are eligible for premium-free group health benefits:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
*If there are any dependent children on your policy, please complete questions 1-3 listed at the bottom - Sign, date, and return this form				
<b>SECTION II – OTHER COVERAGE – YOUR SPOUSE’S BENEFIT PLAN (if applicable)</b>				
Your spouse’s name:		Your spouse’s employer:		
Your spouse’s date of birth:		Is your spouse currently eligible for group health coverage through their employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Your spouse’s benefit plan name:		Your spouse’s benefit plan group #:		
Benefit Plan Eligibility Phone:		Coverage:    ___ Medical    ___ Prescription    ___ Dental    ___ Vision		
Effective Date of Coverage:		Coverage Level:    ___ Family    ___ Single    ___ Single+Dept Coverage Plan: <b>Is this a High Deductible Plan with an HSA?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of your SPOUSE’S Natural child(ren) (please attach separate sheet if necessary)	Child’s Social Security Number	Type of Coverage		Employer the Benefits Are through
		___ Medical    ___ Vision ___ Dental    ___ Prescription	___ None	
		___ Medical    ___ Vision ___ Dental    ___ Prescription	___ None	
___ Medical    ___ Vision ___ Dental    ___ Prescription	___ None			
<b>SECTION III – OTHER COVERAGE – <input type="checkbox"/> EX-SPOUSE   <input type="checkbox"/> NATURAL PARENT (mark one -if applicable)</b>				
Ex-spouse/Natural Parent’s name:		Ex-spouse/Natural Parent’s employer:		
Ex-spouse/Natural Parent’s SSN:		Ex-spouse/Natural Parent’s date of birth:		
Ex-spouse/Natural Parent’s benefit plan name:		Ex-spouse/Natural Parent’s benefit plan group #:		
Effective Date of Coverage:		Type of Coverage:    ___ Medical    ___ Prescription    ___ Dental    ___ Vision Coverage Level:    ___ Family    ___ Single    ___ Single+Dept Coverage Plan: <b>Is this a High Deductible Plan with an HSA?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of YOUR natural child(ren) not listed above (please attach separate sheet if necessary)	Child’s Social Security Number	Type of Coverage		
		___ Medical    ___ Vision ___ Dental    ___ Prescription	___ None	
		___ Medical    ___ Vision ___ Dental    ___ Prescription	___ None	
___ Medical    ___ Vision ___ Dental    ___ Prescription	___ None			
<b>SECTION IV – DEPENDENT INFORMATION (All questions must be answered)</b>				
1. Are any of the dependents on your policy mentioned in a divorce decree or court order? <i>We must have a copy of the divorce decree or court order to process any of your dependent’s claims.*</i>			___ YES    ___ NO	
2. Are any of the adult children on your policy veterans of the military? <i>If Yes, additional information will be required</i> If yes, which children?			___ YES    ___ NO	
3. Are any of your adult dependents eligible for other group health coverage through their or their spouse’s employer? If yes, which children?			___ YES    ___ NO	

\*If there are any dependent children on your policy, you must complete questions 1-3

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date