

**PEIA PPB Plan
Coordination Of Benefits Form**

In order to keep our records current, it is a PEIA requirement that this questionnaire be completed every 12 months. Please return this questionnaire within 30 days to prevent delays in future claim submissions.

Policyholder Name _____

ID Number _____

Address _____

Dependents Covered _____

1. Spouse's Name _____ Date of Birth _____

2. Do you or any of your dependents have other insurance?

Yes **No** if yes: **Single** **Family**

Type of Coverage **Medical** **Rx Drug** **Dental** **Vision** **Hospital**

3. Employee's Name _____

4. Please provide the name, address, and effective date of the other insurance

if Medicare, please advise and give effective date _____

5. Does the other insurance plan use the gender rule or the birthday rule for coordination of benefits? Gender Birthday

6. If the other insurance has terminated, please provide the termination date: _____

Employee Signature _____ Date _____

Day Phone _____

Please return this completed letter within 30 days for prompt handling. If related claims are received requiring this same information, you will not receive additional requests.

Mail To:

**HealthSmart
P O Box 3262
Charleston, WV 25332-3262**