MUTUAL HEALTH SERVICES℠

Coordination of Benefits (ADCOB)

EMPLOYER: _____
EMPLOYEE: _____
ID#: _____
REGARDING: _____

Does your dependent listed above have any other insurance coverage?

☐ **No other coverage besides the plan through the above employer**
☐ **Yes, the other type of coverage is (check type and follow-up information)**
- ☐ **Individually purchased plan from (Name of carrier) _____**
- ☐ **Medicare; if so ☐ Part A? ☐ Part B? Date(s) _____/_____/_____**
  Reason for entitlement: _____
- ☐ **Group Health Plan; if so, (Name of Employer) _____**
  - ☐ **Actively working employee?**
  - ☐ **COBRA; Start date: _____/_____/_____**
  - ☐ **Retiree; Date retired: _____/_____/_____**
  - ☐ **Health Savings Account (HSA); Start Date: _____/_____/_____**
  - ☐ **Military: ☐ Active ☐ Retired?**
- ☐ **Medicaid**

Who carries the other insurance and what is their relationship to your dependent? (e.g., step-parent, mother, father, spouse, self)

Name: _____ Date of Birth: _____/_____/_____

Relationship to your Dependent: _____

Start date _____/_____/_____ and end date _____/_____/_____ (if applicable)

Benefits: Indicate all that apply

Medical:	Sgl ☐	Fam ☐		Dental:	Sgl ☐	Fam ☐	
Rx:	Sgl ☐	Fam ☐		Vision:	Sgl ☐	Fam ☐	

Do you have any other dependents, enrolled on the Mutual Health Services plan, also covered by the other insurance carrier?

☐ **No** ☐ **Yes; Please list: _____**

Additional Information: _____

_____

Employee Signature: _____ Date: _____/_____/_____

Please return this form completed either by:
Fax: 330.666.3836;
Email: mhsadmin@mutualhealthservices.com;
Mail: Mutual Health Services, P.O. Box 5700, Cleveland, OH 44101