Health First Health Plans

Coordination of Benefits Questionnaire

If you are covered by another health insurance policy, please complete this form, sign and date it, and mail it back to us in the enclosed postage-paid envelope.

Member name:_____ Date:_____

Health First Health Plans Member ID:_____ Group number: _____

Other Medical Insurance Coverage

Policyholder's name: First:_____ Last:_____

Policyholder's relationship to you: ❑ Self ❑ Spouse ❑ Child ❑ Other (please specify):_____

Policyholder's date of birth (mm/dd/yyyy):

		/			/				

Insurance carrier name:_____ Employer name:_____

Policyholder's ID number on insurance card:

Policy effective date (mm/dd/yyyy):

		/			/				

Is this medical insurance coverage a retirement benefit? ❑ Yes ❑ No

If Yes, please fill in your retirement date (mm/dd/yyyy):

		/			/				

Other Drug Insurance Coverage

Policyholder's name: First:_____ Last:_____

Policyholder's relationship to you: ❑ Self ❑ Spouse ❑ Child ❑ Other (please specify):_____

Policyholder's date of birth (mm/dd/yyyy):

		/			/				

Insurance carrier name:_____ Employer name:_____

Policyholder's ID number on insurance card:

Policy effective date (mm/dd/yyyy):

		/			/				

Is this drug insurance coverage a retirement benefit? ❑ Yes ❑ No

If Yes, please fill in your retirement date (mm/dd/yyyy):

		/			/				

Signature: _____

Phone:_____ Date:_____

Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal.

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