



COORDINATION OF BENEFITS QUESTIONNAIRE

You can update your coordination of benefits information by calling Network Health's Member Experience Department at the number on the back of your Network Health ID card, Monday–Friday from 8 a.m. to 4:30 p.m. Or, complete this form and return to Network Health.

SECTION 1 YOUR NETWORK HEALTH INFORMATION

Network Health member/participant name (as found on your ID card)	Network Health member/participant ID number
Group name	Group number

In addition to this Network Health contract, are you or any of your covered dependents also covered by another group health care plan? If other insurance coverage is due to divorce, separation or court order please complete section 3. If you have additional Network Health contracts, please include this as other coverage.

☐ **NO** – Please skip the rest of the questions, sign at the bottom and return.

☐ **YES** – Please complete the entire form, sign at the bottom and return.

SECTION 2 OTHER HEALTH COVERAGE INFORMATION

Please provide the following information about the policy holder of the other health coverage. Attach additional pages if needed.

Name of policy holder of other coverage	Relationship to you	Employer	Date of birth	
Insurance company name	Insurance company address	City	State	Zip code
Member/participant ID/policy number	Group number	Effective date	Cancellation date (if applicable)	
Type of coverage ☐ Single ☐ Family	Is this a COBRA contract? ☐ Yes ☐ No Is the policy holder laid off? ☐ Yes ☐ No			

Who is covered by this other plan? Include yourself if applicable.

Name (first and last)	Relationship to you	Social Security Number*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

SECTION 3 SPECIAL SITUATIONS

Fill out this section only if any of your children have health care coverage in addition to the above because of divorce, separation or court order. If not applicable skip the rest of the questions, sign at the bottom and return.

Is there a court order that determines responsibility for health care coverage or custody? ☐ No ☐ Yes

Name of person responsible for child's health care coverage	Social Security Number*	Employer	Date of birth	
Insurance company name	Insurance company address	City	State	Zip code
Member/participant ID/policy number	Group number	Effective date	Cancellation date (if applicable)	

Which children are covered by this insurance?

Child's name (first and last)	Who has custody?	Child's name (first and last)	Who has custody?
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Is coverage for any of the above listed individuals required due to a court order, divorce decree or paternity suit: ☐ Yes ☐ No

Custodial Parent: _____

Primary coverage for dependent carried by: _____

If yes, **please attach a copy of the section of the court order or divorce decree pertaining to health coverage.** If you have previously provided this information to Network Health and that information is still current, you do not need to submit it again.

Signature _____

Subscriber's signature _____ **Date** _____

Return completed forms to: **Network Health**
Coordination of Benefits
P.O. Box 120
Menasha, WI 54952

Fax: **920-720-1868**
Email: **cob@networkhealth.com**

For Network Health Use

Claim Number: _____