**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**