



COORDINATION OF BENEFITS

Primary Subscriber: _____

Date of Birth: _____

Please complete this form in its entirety to ensure your claims are processed timely and accurately. If we receive information and are unable to identify the claimant associated, your records will not be updated and you may experience a temporary interruption of your benefits until the proper information is received.

1. Do you or any family members covered by the [Client Name] medical plan have another medical insurance plan?

☐ No – Please sign the bottom of this form and see submission information below

☐ Yes – Please continue to #2 and see submission information below.

2. Persons covered by other medical insurance plan (If you need additional space, attach a sheet of paper):

First Name	Middle Initial	Last Name	DOB	Is this Court Ordered Coverage?

3. Other Carrier Information:

Primary Policyholder's Full Name		
Full Name: _____		
Date of Birth: _____		
Carrier	Group/Plan Number	Full Member Identification Number

I hereby certify all information given by me is accurate and true.

Employee Signature

Date

Please mail or fax this completed form, **along with copies of other medical ID cards, if applicable**, to:
BRMS, Attn: COB Dept. at PO Box 2140, Folsom, CA 95763 or 916.467.1401 (secured fax line).