

**Coordination of Benefits Information**

Subscriber: \_\_\_\_\_ Group Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

Coverage with ODS: \_\_\_\_\_ Medical \_\_\_\_\_ Dental

**Natural/Adopted Dependents, Covered Spouse**

Do you or any of the covered dependents currently have other Health Insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes: Carrier Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Carrier Phone # \_\_\_\_\_

Dependents covered on plan: \_\_\_\_\_  
\_\_\_\_\_**Determining Primary Carrier and/or Custody**

Custodial Parent: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Noncustodial Parent: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is there a court mandate regarding health coverage? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which parent is mandated? \_\_\_\_\_

If there is a court mandate, please send a copy of the front page and the section reflecting the insurance mandate to ODS.

Dependents this applies to: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_