Coordination of Benefits (COB)

This information will be used to distinguish the order that two or more insurance companies will pay benefits for the same claim. **If you or a dependent has other coverage that will be considered the primary payer for benefit, that individual will not be eligible for benefits under the MSMA plan.** Please complete this form in its entirety and return to Patient Advocates to avoid delay in claim processing.

EMPLOYER INFORMATION

Group Number: 300	**Plan Year:**

SECTION 1: EMPLOYEE INFORMATION

Last Name	First	Middle Initial	Date of Birth	Patient Advocates Account Number

In addition to this MSMA Dental Insurance plan, are you or any of your covered dependents also covered by another dental plan?

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

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

If you or a dependent has other coverage that will be considered the primary payer for benefit, that individual will not be eligible for benefits under the MSMA plan.

SECTION 2: OTHER DENTAL COVERAGE INFORMATION – POLICY HOLDER

Name of policy holder of other coverage	Relationship to you	Social security number	Employer	Birth date
Insurance company name and street address		City	State	ZIP code
Enrollee ID / policy number	Group number	Effective date	Cancellation date (if applicable)	
Type of coverage ☐ **Single** ☐ **Two Person** ☐ **Family**	Type of plan: X Dental			

SECTION 3: OTHER DENTAL COVERAGE INFORMATION – DEPENDENTS

Which dependents are covered by this insurance?

Last Name	First	Middle I	Sex (M/F)	Date of Birth	Social Security Number	Relationship to you

SIGNATURE ______________________________ **DATE** ______________________________

If you have any questions regarding this questionnaire, please contact our Customer Service Representative at (800) 290-8559 or (207) 657-7733.

PATIENT ADVOCATES, LLC
P.O. BOX 1959
GRAY, ME 04039