Annual COB Update

Last Name	First Name, M.I.	Gender	DOB
		M F	

Home Street Address	City, ST, Zip	Home/cell Phone

Marital Status (circle one)	Email Address	Work Phone
Single Married Widowed Divorced		

DEPENDENT INFORMATION: List only those dependents being covered on the healthcare plan.

First Name	Last Name (if different)	DOB	Gender	Relationship
			M F	
			M F	
			M F	
			M F	
			M F	
			M F	
			M F	

SECONDARY & OTHER COVERAGE:

This information is used for Coordination of Benefits purposes, and/or to assist individuals who may qualify for alternative benefits coverage.

Are you covered on your spouse's plan through his/her employer? **_____YES _____NO** Is your spouse covered where they work? **____YES ____ NO**

Spouse's Employer **Employer Phone No.** **Type of Coverage (check one)**

____Emp. Only, ____Emp/Spouse, ____Emp/Child, ____Family

Has your spouse previously declined coverage they are eligible for through their employer? **_____ YES _____ NO**

Do you or any of your dependents have coverage through **Medicare**? _____YES _____NO Who? ____Self, ____Spouse, ____Child(ren)

Medicare Eligibility due to: ____Age, ____Disability, ____Kidney Failure Type of Coverage: ____Part A, ____Part B, ____Part D

Are any of your dependents totally or temporarily **Disabled**? ____YES ____NO Date of Disability/who:_____

Do you, your spouse or your dependents have coverage through **Medicaid**? ____YES ____NO Who? ____Self, ____Spouse, ____Child(ren)

Do you, your spouse or your dependents have coverage through **Tri-Care**? ____YES ____NO Who? ____Self, ____Spouse, ____Child(ren)

Applicant Signature:_____ Date:_____

Subscriber Acknowledgement: Under penalties or perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. It is fraudulent to submit information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse Cape Girardeau Public School #63 Health Care Plan for any money it was induced to pay as a result of the information I provided. Receipt and/or completion of this form is not a guarantee or eligibility.