exceedent

W129 N7055 Northfield Drive • Menomonee Falls, WI 53051
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Coordination of Benefits Form

Welcome to Exceedent! As the third party administrator for your employer's medical plan, we require an annual Coordination of Benefits (COB) review. The COB review verifies if you or any of your covered family members have additional medical coverage. For example, you may have your family on your employer's medical plan as well as your spouse's medical plan, court ordered insurance coverage from a former spouse, coverage required in a divorce decree or paternity suit, or Medicare.

To ensure that you and your family's medical claims are processed correctly, please complete this form within 30 days to avoid any delay that may result in all subsequent claims being pended until your form is received.

Employee Name (print): _____ **Group No.** _____

Member ID: _____ **Contact Number** (if additional information is needed)**:** _____

Please answer the question below. If you answer yes, please complete the rest of this section.

Are you or any of your family members covered under any other group medical or Medicare? ☐ Yes ☐ No

If no, skip the remainder of the form and provide your signature at the end.

Effective Date of Other Coverage: _____ (required)

****If you have more than one policy in force, please attach a separate sheet to this form which lists the following information for each policy. *Also include a photo copy of your insurance card.***

*****If other coverage terminated from prior year, indicate insurance name and term date:***

Types of Coverage (please check all that apply) Medical Medicare Medicaid	Policyholder's Name	Policyholder's Birthdate / /
Policyholder's Employer Name	Address	Phone Number ( )
Insurance Company Name	Policy Number	Policyholder's Member ID

Family Members Covered

Name: Last, First, MI	Relationship to you	Social Security Number
		– –
		– –
		– –
		– –
		– –

Medicare ID #	Medicare Part A Eff. Date: / /	Medicare Part B Eff. Date: / /	Is Medicare eligibility due to: ☐ Kidney Failure ☐ Disability ☐ Age

Is coverage for any of the above listed individuals required due to a court order, divorce decree or paternity suit: ☐ Yes ☐ No

Custodial Parent: _____ Primary coverage for dependent carried by: _____ If yes, please attach a copy of the section of the court order or divorce decree pertaining to health coverage. If you have previously provided this information to Exceedent and that information is still current, you do not need to submit it again.

Member Information & Signature

I hereby certify that the information I have provided above is true and correct and, I authorize any insurance company, plan administrator, or educational institution to release any information regarding other insurance coverage or student status regarding me or my covered dependents to Exceedent for the purpose of benefit coordination.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION ON THIS FORM MAY RESULT IN THE DENIAL OF CLAIM(S) AND/OR TERMINATION OF COVERAGE.

Employee ~~Signature:~~ _____ **Date:** _____

Please submit via one of the following options: Complete **online at www.exceedenthealth.com**, Return by email at: **enrollment@exceedenthealth.com,** by fax to **262-532-5245** or by mail to **Exceedent • Attn: Enrollment/COB • W129 N7055 Northfield Drive • Menomonee Falls, WI 53051**