



Please fax completed form to: 330-996-8953

Remember to include the following information, if applicable, with your completed COB form:

- Attach a copy of your other Insurance ID card(s)
- Attach a copy of your court order if applicable

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

DO YOU OR ANY PARTICIPATING DEPENDENTS CURRENTLY HAVE OR HAD OTHER MEDICAL, PHARMACY, DENTAL, OR VISION INSURANCE COVERAGE WITHIN THE LAST 12 MONTHS?

YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, Please complete the following information and enclose a copy of the other medical/pharmacy vision and dental insurance Identification (ID) Card(s):

If NO, Please sign the bottom and return this form to SummaCare

OTHER INSURANCE INFORMATION

Policy/Contractholder Relationship to Employee  
 Holder's Name \_\_\_\_\_

Active \_\_\_\_\_ Retired \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_ Coverage Termination  
 Date (if applicable) \_\_\_\_\_

Policy Covers: Medical \_\_\_\_\_ Pharmacy \_\_\_\_\_ Dental \_\_\_\_\_ Vision \_\_\_\_\_  
 Policy Type: Single \_\_\_\_\_ Employee + One \_\_\_\_\_ Family \_\_\_\_\_

Name and Address of Employer: \_\_\_\_\_  
 Name of Insurance Company: \_\_\_\_\_  
 Insurance Company Address: \_\_\_\_\_  
 Insurance Company City, State, Zip: \_\_\_\_\_  
 Insurance Company Telephone Number: \_\_\_\_\_

Please list names, date of birth, and relationship of those covered under the above policy.

Last Name	First Name	MI	Date of Birth	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IS THERE A STANDING "COURT ORDER/DECREE" FOR "MEDICAL COVERAGE" FOR ANY PARTICIPATING DEPENDENT CURRENTLY COVERED UNDER THIS PLAN?

YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please provide a copy of the court order along with this form

Name of Custodial parent: \_\_\_\_\_

MEDICARE INFORMATION

Do you or a member of your family have Medicare Part A and/or Part B? YES \_\_\_\_\_ NO \_\_\_\_\_

Medicare is for: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Dependent \_\_\_\_\_  
 Medicare Recipient Name: \_\_\_\_\_ Medicare ID Number: \_\_\_\_\_  
 Effective Date Part A: \_\_\_\_\_ Effective Date Part B: \_\_\_\_\_  
 Medicare Coverage is the result of (please check one) and indicate date associated with event:  
 Age (65 years) \_\_\_\_\_  
 End-Stage Renal Disease \_\_\_\_\_ Date of First Dialysis \_\_\_\_\_  
 Transplant \_\_\_\_\_ Date of Transplant \_\_\_\_\_  
 Disability \_\_\_\_\_ Date approved for Medicare benefits \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Ohio Revised Code Section 3999.21 – Insurance Fraud Warning

“Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.”