



Dear Fletcher Allen Preferred Medical Plan Participant:

Please take a moment to complete this Coordination of Benefits form. Failure to complete this form will delay claims processing.

COORDINATION OF BENEFITS (COB) FORM

Employee Name: _____ Employee Identification Number: FA _____

HAVE YOU OR ANY PARTICIPATING DEPENDENTS HAD OTHER MEDICAL INSURANCE COVERAGE WITHIN THE LAST 12 MONTHS? Yes _____ No _____

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

If NO, Please fill in your employee name and employee ID number and sign the bottom.

OTHER INSURANCE INFORMATION

Policy Holder's Name _____ Relationship to Employee _____
Active _____ Retired _____ Policy Holder Date of Birth _____
ID # _____ Group # _____ Effective Date _____ Term Date (if applicable) _____
Policy Covers: Medical _____
Policy Type: Single _____ Employee + One _____ Family _____

Name of Insurance Company: _____
Insurance Company Address: _____
Insurance Company Telephone Number: _____

Please list covered dependents, their dates of birth, and relationship to the policy holder. If you need more space, please continue on the reverse side of this page.

Table with 5 columns: Last Name, First Name, MI, Date of Birth, Relationship to Policy Holder

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

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 qualifying event:

Age (65 years) _____ NO _____
End-Stage Renal Disease _____ Date of First Dialysis _____
Transplant _____ Date of Transplant _____
Disability _____ Date approved for Medicare benefits _____

EMPLOYEE SIGNATURE _____ DATE _____

Please return this form in the enclosed envelope to Vermont Managed Care or fax to (802) 847-6213
If you have questions regarding this form please call VMC at (802) 847-4862 or (866) 582-6836