COORDINATION OF BENEFITS INQUIRY

Please complete this form in entirety. If we receive information and are unable to identify the claimant associated we will be unable to reconsider payment on that claim. Delay in claim processing may occur due to incomplete information.

This information will be requested annually. Should you have a change in your insurance status or any dependents listed acquire other coverage prior to our next inquiry, please notify TRISTAR Benefit Administrators immediately.

SECTION I *(Please Print)*

Employee:	
Group Number:	Employee ID Number:

SECTION II

Do you or any dependents have other health insurance?	NO	YES *(go to Section III)*
Do you or any dependents have Medicare?	NO	YES *(go to Section IV)*
Do you or any dependents have Medicaid?	NO	YES *(go to Section V)*

SECTION III

Name of Person carrying other coverage:	
Please provide the health insurance information below; including Medical, Dental and Vision:	
Company Name:	
Effective Date of Coverage:	Termination Date (if applicable):
Other Plan Covers: Medical Dental Vision	
Dependents Covered:	

SECTION IV

How do you qualify for Medicare Coverage?		Age	Disability	Other
Effective Date of Coverage:	Termination Date (if applicable):			
Which Part of Medicare are you eligible?	Part A	Part B	Part C	Part D
Please provide effective dates for each coverage, if different.				

SECTION V

Please list each dependent receiving Medicaid and their effective date *(and termination date, if applicable).*

SECTION VI

Are any of your dependents required by court order (divorce, family, or other) to be covered by you, your spouse, or ex-spouse? NO YES *(please provide copy of court order)*

I understand that the information provided will be used in determining benefits under my health plan, and I certify that the information provided is true and accurate to the best of my knowledge.

_____ _____

Employee Signature Date

Return this information and any supporting documentation to TRISTAR Benefit Administrators; 3900 Westown Parkway, Suite C; PO Box 65887; West Des Moines, IA 50265 or via fax at 515-453-8210 or send email with requested information at #TBA-Claims@tristargroup.net.