ALLEGIANCE BENEFIT PLAN MANAGEMENT

2806 S. Garfield
PO Box 3018
Missoula, MT 59806-3018
1-800-877-1122 or (406) 721-2222

Date: __________________

Group ID: ________________
Group Name: ___________________________________
Participant: _____________________________________
Participant ID #: _________________________________
Patient Name: ______________________________________

We have received information that there may be other insurance coverage. Please complete the following questionnaire and return it to the address above or fax it to 1(866) 201-0522. If you have questions please contact our customer service department at the number above. Thank you in advance for your prompt attention to this request.

COORDINATION OF BENEFITS

Do you or any other family member have other insurance coverage? ___Yes ___No
If yes, please complete the following:

Names of family members who have other coverage:

Name	Date of Birth	Name	Date of Birth
Name	Date of Birth	Name	Date of Birth
Name	Date of Birth	Name	Date of Birth

Name of other insurance coverage____

Address ____

City, State, Zip ____

Phone Number ___________________________ Group Number ______________________________

Policy Number ___________________________

*****EFFECTIVE DATE OF COVERAGE**___________________

Name of Policy Holder ____

Social Security Number_______________________

Address of Policy Holder ____

City, State, Zip ____

Participant: ______________________________ Participant ID #: __________________________
Group Name: ____________________________ Group ID #: ______________________________
Claimant: _______________________________ Date of Service: ___________________________

Type of coverage: ___Medical ___Dental ___Vision ___Life ___Auto ___Pharmacy ___Disability

Please read the following statement and answer any questions below which are applicable.

When parents of a dependent child are divorced or separated, or in the case of a single parent, the coverage of the parent with custody of the child normally pays first unless there is a court order which says the other parent is responsible for the child's expenses. In order to determine which coverage has primary liability on the above child/children, please complete the following:

What was the date of the divorce or separation? ____

Which parent has physical custody of the child? ____

Is there a court order making one parent responsible for the child's medical/dental/vision expenses?
____ Yes ____ No

*****IF YES, PLEASE PROVIDE A COPY OF THE COURT ORDER WITH THIS FORM.**
*****IF YES, WHAT WAS THE EFFECTIVE DATE OF COVERAGE?** ___________________

Has the parent with custody remarried? ____ Yes ____ No

If yes, does the step-parent cover this child? ____ Yes ____ No

I certify that the above information is true to the best of my knowledge. I authorize any physician, facility, insurance company, or employer to release information to the Plan Supervisor/Claims Processor.

____ _______________
Signature of Employee Date

____ _______________
Signature of Dependent (if over 18 years of age) Date

____
Printed Name of Person Signing Form

Some states require that we notify you "Any person who knowingly with intent to defraud, or deceive an insurance company or employee benefit plan, files a false statement containing false, incomplete, or misleading information is guilty of a felony of third degree."