

Please complete all applicable sections below and return this Coordination of Benefits (COB) form as soon as possible to:

PacificSource Health Plans
ATTN: COB Dept.
 PO Box 7068
 Eugene, OR 97401-0068
 Fax (541) 225-3654

If you have any questions about this form, please call our COB Department at (541) 686-1242 x 2685 or toll-free at (800) 624-6052 x 2685.

Group Policy No.	Group Name	PacificSource ID No. (on ID Card), if known		
Employee Information				
Employee Last Name	First Name	M.I.	Date of Birth month _____ day _____ year _____	
Other Coverage				
Current Other Coverage Information – Do you or any person listed on this application have other dental, vision, or health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete the following.				
Name(s)	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
Medicare – If you or any person on this application have Medicare, is coverage? <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D				
Name	Original Effective Date	Medicare No. (include alpha prefix)	Reason for Medicare Entitlement	
			<input type="checkbox"/> Age <input type="checkbox"/> ERSD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement	
Declaration				
I affirm that the answers given in this application are complete and correct.				
_____ Employee Signature			_____ Date	