Simplified Benefits Administrators
Other Insurance Letter (COB Form)

Employee Name:	Group Number:
Patient Name:	Claim Number:
Member ID Number:	Date of Service:
Employee/Member Phone Number:	

Our records indicate that we need updated information on possible other insurance coverage for your family. This information is only requested annually, on the initial claims, or due to a change in status.

In order to properly administer your benefits, we need to know if anyone in the family has any other insurance coverage. Other coverage would include group coverage through an employer other than the one referenced above, Medicare, Medicaid, any other type of coverage, including coverage mandated by a decree or through a non-custodial parent.

Does anyone in the family have other medical or dental coverage? (circle one)

Yes or No

If NO, sign and return this form as indicated on the next page.

If YES, please complete the following information:

Medical Coverage
Name of Carrier_____
Phone Number of Carrier _____
Policyholder's ID Number _____
Policyholder's Date of Birth _____
Effective Date of Coverage _____
Is this single or family coverage?_____
If single coverage, what family member is covered on the plan? _____ If family coverage, what family member(s) are covered on the plan? _____ Is this a group policy?_____ or an individual/supplemental policy?_____

Dental Coverage
Name of Carrier_____
Phone Number of Carrier _____
Policyholder's ID Number _____
Policyholder's Date of Birth _____
Effective Date of Coverage _____
Is this single or family coverage?_____
If single coverage, what family member is covered on the plan? _____ If family coverage, what family member(s) are covered on the plan? _____ Is this a group policy?_____ or an individual/supplemental policy?_____

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Is a member of your family a full-time student attending college out-of-state? (circle one)

Yes or No

If YES, please complete the following information and submit a copy of the student's transcript:

Out-of-State College Student
1. Member Name: _____
2. Member ID #: _____
3. College Name: _____
4. Student ID #: _____
5. Credit Hours: _____

Please sign and date below, and provide us with your phone number in order for us to contact you in the event we have more questions.

Signature of Enrollee _____

Date signed _____

Phone number _____

Please submit requested information as soon as possile to ensure the appropriate and timely processing of current and future claims.

Thank you for your cooperation.

Email: customerservice@simplifiedbenefitsadministrators.org

Fax: 801.442.0041

Mail: ATTN: Claims Department
10375 Park Meadows Drive, Suite 125
Lone Tree, CO 80124