Auxiant®

PO Box 259710, Madison, WI 53725-9710

XXXXX

Date:
Group Number:

Re: Coordination of Benefits (COB) - Response Required

Dear Member,

Periodically, Auxiant will check with you to determine if you or your dependents have any other coverage in addition to the coverage you have with Auxiant. This is necessary to determine if other parties are responsible for payment and the order of payment as outlined in your plan document.

In order to verify this information, please complete and return the attached Coordination of Benefits form on the reverse side of this letter. ***Remember, all sections need to be completed.*** Please mail (self-addressed envelope included) or fax the completed form to:

Auxiant Enrollment Department
PO Box 259710
Madison, WI 53725-9710
Fax 608-270-7837

You can now complete this questionnaire online as well at www.auxiant.com or call 800-279-6772 to provide COB information over the phone.

Please return the enclosed form by XXXX. **Your response is required in order for Auxiant to process future claims. If we do not receive your Coordination of Benefits (COB) response your future claims will be denied without payment.** If we receive this form at a later date but within the plan limitations, we will consider your claims for payment at that time.

Remember: if there is any change in status for any covered member, you are required to contact the plan sponsor within 31 days of the date this change occurs. If you do not notify the plan sponsor within this time frame, the date of the change will be used as the date for which coverage for you or the dependent(s) may terminate.

If you have any questions call 800-279-6772.

Sincerely,

Enrollment Department
Auxiant - Your Integrated Benefits Partner

QR 10095468

Coordination of Benefits Request Employee Name: XXXXXXX BirthDate: 00/00/00 Member ID: 000000000

Phone Number: Information Not Provided

New Phone Number: _____

Email Address: Information Not Provided

New Email: _____

Address: [See Address on Front of Letter]

New Address: _____

Address City State Zip

QR 10095468

s) SPOUSE (00/00/00) Does a divorce decree or child support order exist for this dependent? ☐YES ☐NO If yes, please attach

M) Enrolled in OTHER Medical Coverage? ☐Yes ☐No (if No, move to next question)

_____ ___/___/___
Other Medical Policy Holder Name Birthday

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child

Other Coverage From: ___/___/___ To: ___/___/___

Type of Other Coverage: ☐Medicaid ☐Commercial ☐Medicare (see below) ☐Tricare

Medicare Part A: ☐Yes ☐No | Part B: ☐Yes ☐No | Part D: ☐Yes ☐No

Eligibility Reason: ☐Age ☐ESRD ☐Disability

D) Enrolled in OTHER Dental Coverage? ☐Yes ☐No (if No, move to next question)

_____ ___/___/___
Other Dental Policy Holder Name Birthday

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child

Other Coverage From: ___/___/___ To: ___/___/___

Type of Other Coverage: ☐Medicaid ☐Commercial ☐Tricare

1) DEPENDENT 1 (00/00/00) Does a divorce decree or child support order exist for this dependent? ☐YES ☐NO If yes, please attach

M) Enrolled in OTHER Medical Coverage? ☐Yes ☐No (if No, move to next question)

_____ ___/___/___
Other Medical Policy Holder Name Birthday

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child

Other Coverage From: ___/___/___ To: ___/___/___

Type of Other Coverage: ☐Medicaid ☐Commercial ☐Medicare (see below) ☐Tricare

Medicare Part A: ☐Yes ☐No | Part B: ☐Yes ☐No | Part D: ☐Yes ☐No

Eligibility Reason: ☐Age ☐ESRD ☐Disability

D) Enrolled in OTHER Dental Coverage? ☐Yes ☐No (if No, move to next question)

_____ ___/___/___
Other Dental Policy Holder Name Birthday

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child

Other Coverage From: ___/___/___ To: ___/___/___

Type of Other Coverage: ☐Medicaid ☐Commercial ☐Tricare

2) DEPENDENT 2 (00/00/00) Does a divorce decree or child support order exist for this dependent? ☐YES ☐NO If yes, please attach

M) Enrolled in OTHER Medical Coverage? ☐Yes ☐No (if No, move to next question)

_____ ___/___/___
Other Medical Policy Holder Name Birthday

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child

Other Coverage From: ___/___/___ To: ___/___/___

Type of Other Coverage: ☐Medicaid ☐Commercial ☐Medicare (see below) ☐Tricare

Medicare Part A: ☐Yes ☐No | Part B: ☐Yes ☐No | Part D: ☐Yes ☐No

Eligibility Reason: ☐Age ☐ESRD ☐Disability

D) Enrolled in OTHER Dental Coverage? ☐Yes ☐No (if No, move to next question)

_____ ___/___/___
Other Dental Policy Holder Name Birthday

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child

Other Coverage From: ___/___/___ To: ___/___/___

Type of Other Coverage: ☐Medicaid ☐Commercial ☐Tricare

Please sign and return to Auxiant in order to not interrupt claims processing.

I hereby certify that the above information is true to the best of my knowledge.

_____ ____/____/____
Signature Date