# MAKING CLAIMS IF SPOUSE/DEPENDENTS ALSO COVERED UNDER ANOTHER PLAN

If you, your spouse or your dependents are also covered by another plan (such as through your spouse's employer), you may need to submit your family's health and dental claims to both plans. This process is called Co-ordination of Benefits.

**If the claim is for you** (you are the patient) – submit the claim to your health or dental plan first, by completing the claim form. Keep a copy of the claim form. Once the Plan Administrator has assessed and/or paid the claim, you will receive a written explanation. Then submit the claim (with the explanation and copy of the original claim form) to your spouse's benefit plan to be reimbursed for the remaining portion.

**If the claim is for your spouse**, (he/she is the patient) – submit the claim to your spouse's health plan first. Complete the claim form for that plan and keep a copy of the claim form. Once your spouse's plan has assessed and/or paid the claim, then submit the claim to the Plan Administrator for them to assess the claim. Send the Plan Administrator the explanation that the other plan sent to your spouse, along with the copy of the claim form that you kept. You will need to attach and sign a completed claim form.

**If the claim is for your dependent child**, the parent whose birth date (month and day) occurs first in the year, submits the claim to their plan first. The other parent then submits the remaining portion of the claim to their plan (see the instructions above).

Co-ordination of benefits makes sure that you can receive reimbursement of your claims from both benefit plans up to the full cost of your claim. It is not intended that you receive reimbursements greater than the actual heath/dental expenses incurred. Therefore, any coverage you have under other "plans" will be taken into account in determining the amount of benefit payable under this Plan, and the benefits under this Plan will be co-ordinated with the benefits of the other plans.

## IMPORTANT NOTE

The Board of Trustees/Employer has the power to disentitle any person to past, present or future benefits and to take any further action deemed appropriate, including denying membership in the Plan to any person where the member or persons claiming through the member are found by the Trustees/Employer to be abusing the plan or making false or improper claims under the Plan.

# CO-ORDINATION OF BENEFITS FORM

| | |
|---|---|
| **Plan or Employer Name:** | |
| **Your Name:** ***(please print)*** | |
| **Date of Birth:** | |
| **Certificate No:** | |
| **Spouse's Name:** ***(please print)*** | |

**Please complete the applicable section below**

1) ☐ **ADDING CO-ORDINATION OF BENEFITS**

Effective date of other coverage: / /
dd / mm / yyyy

Spouse's Insurance Company:

Spouse's Policy Number:

Spouse's Benefits:

| **Health: Check One** | **Dental: Check One** | **Vision Care: Check One** | **Drugs: Check One** |
|---|---|---|---|
| Single Health ☐ | Single Dental ☐ | Single Vision Care ☐ | Single Drugs ☐ |
| Family Health ☐ | Family Dental ☐ | Family Vision Care ☐ | Family Drugs ☐ |
| No Health ☐ | No Dental ☐ | No Vision Care ☐ | No Drugs ☐ |

2) ☐ **TERMINATING CO-ORDINATION OF BENEFITS**

Effective date of Termination: / /
dd / mm / yyyy

Reason for Termination: ______________________________________________
______________________________________________

## AGREEMENT OF UNDERSTANDING

I agree that, should the information provided change in the future it is my responsibility to advise the Plan Administrator, in writing, by completing and filing a revised Co-ordination of Benefits Form.

In addition, I understand that any mis-information or false statements may affect eligibility for benefits for me and my dependents under this Plan.

______________________ ______________________
Signature of Member Date


Plan Administrator:
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