HEALTH REPUBLIC
INSURANCE

Coordination of Benefits Form

Please complete and mail to Health Republic Insurance of New York
2425 James Street, Syracuse, NY 13206 or fax to 315.703.4894

Section 1. Member Information (please print). To be completed by the person who enrolled for the Health Republic Insurance of New York health care plan.

Member Name (as listed on member ID card):	Member ID Number:	Plan Number:
Spouse's Name (if applicable):	Spouse's Date of Birth (if applicable):	

Section 2. Enrollee and Dependent Information. Please complete the fields for each member enrolled in your Health Republic Insurance of New York health plan, listing all covered individuals (including you, your spouse and dependents). For each individual indicate if there is other coverage available in addition to the Health Republic Insurance of New York health plan. For additional dependents, please complete and attach a separate sheet of paper.

Name	**Relationship** (Spouse/ Dependent)	**Date of Birth**	**Does this person have other coverage?** (Circle one)	**Name of other insurance company or "Medicare" – *if "Medicare" complete both sides of form***	**Coverage Type** (Circle all that apply)	**Plan Type** (Circle all that apply)	**Coverage Effective Date** (month/year)	**If known, Coverage Termination Date** (month/year)
	Self		Yes No		Medical Rx Dental Vision	Active COBRA Survivor Retiree Eff. Date: ___/___/___		
			Yes No		Medical Rx Dental Vision	Active COBRA Survivor Retiree Eff. Date: ___/___/___		
			Yes No		Medical Rx Dental Vision	Active COBRA Survivor Retiree Eff. Date: ___/___/___		
			Yes No		Medical Rx Dental Vision	Active COBRA Survivor Retiree Eff. Date: ___/___/___		
			Yes No		Medical Rx Dental Vision	Active COBRA Survivor Retiree Eff. Date: ___/___/___		

Section 3. Required Attachments. Failure to provide the required attachments may result in delayed claim payment.

1. Please provide a copy of each insurance/Medicare card that corresponds with the other coverage information provided in Section 2.
2. If your spouse and/or dependents have other coverage as a result of a legal agreement (divorce/separation/other), please provide a copy of the agreement(s).

Section 4. Member Verification. I certify that the above statements regarding coordination of benefits are complete and true to the best of my knowledge. I authorize release of any information requested with respect to this document. I also understand that I am obligated to inform my employer of any change in the information provided. Any person who knowingly presents false or fraudulent information or files a claim containing any materially false information, commits a fraudulent insurance act, which is a crime, and may be subject to a civil and criminal penalties.

Print Name:	Signature:	Date: