SAG-AFTRA HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880 • www.sagaftraplans.org/health

Coordination of Benefits (COB) Questionnaire Form

In order for us to process claims for you and your dependents, you must complete this Coordination of Benefits questionnaire and return it to us. If we don't receive the completed, signed form, future claims may be denied without further notice. In that event, you or your provider will have 180 days to either provide the required information or appeal the denial.

Participant name: _____

Health care ID (HCID): _____

Aside from your SAG-AFTRA Health Plan and/or Medicare, are you, your spouse or children covered by another health insurance plan? ◉ Yes ○ No

If yes, who is the insured? _____ Insured's health care ID number: _____

Name of other plan: _____ Other plan's phone: _____

Effective date of coverage: _____ Termination date: _____
Coverage type: ○ Group (through employer) ○ Individual/private (obtained on own)
Coverage status: ○ Active ○ Retiree ○ COBRA Level of coverage: ○ Family ○ Individual
List family members covered: _____

Do you or any other family member <u>qualify</u> for coverage with any other entertainment industry health plan, regardless of whether or not you paid the premium for that coverage? ○ Yes ◉ No

If yes, name of person who qualified for coverage: _____

Name of other industry plan: _____ Qualifying person's ID number: _____

Effective date of coverage: _____ Termination date: _____
Coverage status: Active Retiree COBRA Level of coverage: Family Individual

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_____ _____
Participant signature Date

Please disregard this form if you have already returned a completed form to the Plan.

To complete this form online simply log in to your Benefits Manager at https://my.sagaftraplans.org/health. Click on Menu, Go Paperless, then Forms and Letters. If you have additional questions, please call us at (800) 777-4013.