



**City of Colorado Springs Coordination of Benefits Form (COB)**

**Complete and return to AmeriBen/IEC Group only if you are participating in a Medical Plan.**

In order to accurately process your medical claims, it is necessary for AmeriBen/IEC to know if you, as the policyholder/employee of the City of Colorado Springs, or your enrolled dependents have coverage under any other medical insurance policy. This form may also be completed electronically online at <https://www.myameriben.com>. **Failure to return this form will result in delayed payment or denial of medical claims.**

Refer to your Medical Plan Document for claim processing rules surrounding coordinating medical claim payments with other insurance policies and mandatory federal regulatory reporting requirements for the purpose of coordinating with Medicare benefits.

If you have any questions contact AmeriBen/IEC Group at 866-955-1482 or by email at [custserv@ameriben.com](mailto:custserv@ameriben.com).

Print Policyholder's/Employee's Name: \_\_\_\_\_ Policyholder's/Employee's ID# : \_\_\_\_\_

Policyholder's/Employee's Date of Birth: \_\_\_\_\_

1. Did you, your spouse or any of your eligible dependent children have any other medical insurance coverage in the last 12 months in addition to this policy?  Yes  No If other insurance terminated, provide termination date: \_\_\_\_\_
2. Do any dependents (spouse, children) currently have other insurance coverage in addition to the City of Colorado Springs policy?  Yes  No If **Yes**, please provide dependent's Social Security # and Medicare's HCIN # (if applicable):

Dependent's Name	Date of Birth	Social Security #	Medicare's HCIN #

3. Do you or your enrolled dependents have Medicare coverage?  Yes  No If **Yes**, please include the name(s) of any persons covered by Medicare and indicate coverage type below:

Medicare-covered Individual	Type of Coverage(s) (Indicate Part A, B, C, D, or ESRD*)	Medicare's HCIN #	Social Security #	Effective Date

\*If Medicare coverage related to End-Stage Renal Disease (ESRD, please provide the following information:

Effective Date of ESRD Coverage: \_\_\_\_\_ Date of Initial Diagnosis: \_\_\_\_\_

Date of Initial Dialysis: \_\_\_\_\_ Date of Transplant: \_\_\_\_\_

Have you completed a self-dialysis training program?  Yes  No

If you answered **No** to questions 1, 2 & 3, please disregard Questions 4 & 5 and sign and date below.

4. Other Medical Insurance Coverage Information:

Policy Holder's Name	Policy Holder's Date of Birth	Name, Phone and address of other Insurance Policy	Policy Number	Effective Date of Policy
Name, Date of Birth, and Social Security Number of all other dependents covered under the other Insurance Policy:				

Other Medical Insurance Coverage Information:

Policy Holder's Name	Policy Holder's Date of Birth	Name, Phone and address of other Insurance Policy	Policy Number	Effective Date of Policy
Name, Date of Birth, and Social Security Number of all other dependents covered under the other Insurance Policy:				

5. If your dependent children are covered under another policy and the natural parents are divorced or separated, provide the following information:

Do parents have joint custody?  Yes  No If **No**, provide the name of the parent and their address who has with primary custody: \_\_\_\_\_

If divorced, is there a court order in place mandating which policy pays first?  Yes  No If **Yes**, please submit a copy of the divorce decree with this completed form. Claims will not be processed until the divorce decree is received.

Does AmeriBen/IEC Group already have a copy of the divorce decree on file?  Yes  No If **Yes**, it is not required that another copy be submitted.

The above information is complete and accurate to the best of my knowledge, and I understand that failure to include all required information may cause my claims and/or my dependents' claims to be pended or denied. If the information on this form changes, I will notify AmeriBen/IEC Group in writing so that my records will be updated in order to provide accurate medical claims processing information.

Employee's Signature: \_\_\_\_\_ ID# \_\_\_\_\_ Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

*According to the Department of Labor regulations, we are required to complete the processing of your claim within thirty (30) days of receipt, or utilize a fifteen (15) day extension. This letter will notify you that we are using the additional fifteen (15) days because we have not yet received the necessary information to complete your claims. If we do not receive the information in the next fifteen (15) days, we will be required to deny the claim. If we subsequently receive this information, the file will be reopened and your claim will be processed according to plan benefits.*

**After completing this form, fax to 208-424-0595 or mail to AmeriBen/IEC Group, P.O. Box 7186, Boise, ID 83707-1186. Keep a copy for your records.**