Coordination of Benefits

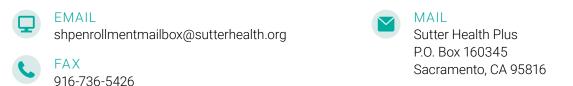
Sutter Health Plus

When an individual has health coverage through two or more healthcare plans, the plans must work together to pay claims. This process is coordination of benefits.

You must complete this form if you, your spouse or your dependents are covered by Sutter Health Plus and another health plan or insurance company at the same time. Failure to provide true and complete information may result in delay or denial of claim payments.

Do not complete this form if other healthcare coverage ends when Sutter Health Plus coverage begins.

Email, fax or mail your completed form to:



Section A – Sutter Health Plus Subscriber Information

Group Name	Member ID # Date of Birth		th
Last Name	First Name	i	MI
Address	City	State	ZIP
Phone	Email	.	

Section B - Other Healthcare Coverage and Subscriber Information

		Group Policy #	Group Policy #		
		Coverage Effective Date	Coverage End Date		
S	Subscriber Last Name	Subscriber First Name	Date of Birth	Subscriber ID #	

Type of Coverage

COBRA	Medicare (Check all that apply)	
Group	Age 65+	
Individual	Part A	
	Part A & B	
	Part D	
	Disabled	
	End Stage Renal Disease	

Medi-C	al
Other:	



Section C – Other Healthcare Coverage Beneficiary Information				
List all Sutter Health Plus members covered under the health plan/insurance company listed in Section B and their relationship to the subscriber of that plan. Include yourself, if applicable.				
Beneficiary 1				
Last Name	First Name	Date of Birth		
Relationship to SubscriberSpouse/Domestic PartnerChild	Other	Other Health Plan/Insurance Company ID #		
Beneficiary 2				
Last Name	First Name	Date of Birth		
Relationship to SubscriberSpouse/Domestic PartnerChild	Other	Other Health Plan/Insurance Company ID #		
Beneficiary 3				
Last Name	First Name	Date of Birth		
Relationship to SubscriberSpouse/Domestic PartnerChild	Other	Other Health Plan/Insurance Company ID #		
Beneficiary 4				
Last Name	First Name	Date of Birth		
Relationship to SubscriberSpouse/Domestic PartnerChild	Other	Other Health Plan/Insurance Company ID #		
Beneficiary 5				
Last Name	First Name	Date of Birth		
Relationship to SubscriberSpouse/Domestic PartnerChild	Other	Other Health Plan/Insurance Company ID #		
Beneficiary 6				
Last Name	First Name	Date of Birth		
Relationship to SubscriberSpouse/Domestic PartnerChild	Other	Other Health Plan/Insurance Company ID #		

Section D – Sutter Health Plus Subscriber Signature

By signing this form, I declare that the information I have provided is true and complete. I understand that if benefit payments are incorrectly or improperly made, I shall be fully responsible to Sutter Health Plus for repayment of all costs, fees and expenses related to such payments. Further, I understand that to the extent permitted by law, Sutter Health Plus may deny benefits and retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility.