



Coordination of Benefits Questionnaire

As a student and/or dependent enrolled in a Student Health Insurance Plan, it is a requirement to provide other health coverage information. This Coordination of Benefits (COB) Questionnaire contains questions about other forms of medical insurance you have. COB helps to ensure that members covered by more than one plan will receive the benefits they are entitled to while avoiding overpayment by either plan. Coordinating benefits is one of the ways to keep premiums at a minimum. Even if you do not have other medical insurance, please complete and sign the form. This will help prevent delays in paying medical claims on your behalf.

Are you covered as the Enrollee or the Dependent? Enrollee Dependent

ENROLLEE INFORMATION	
Name:	
DOB:	
Member ID:	
Gender (Check One):	<input type="checkbox"/> M <input type="checkbox"/> F
School Name:	
DEPENDENT INFORMATION	
Name:	
DOB:	
Member ID:	
Gender (Check One):	<input type="checkbox"/> M <input type="checkbox"/> F
OTHER MEDICAL COVERAGE	
Do you have other medical coverage? (Check One):	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Name of Insurance Company:	
Address of Insurance Company:	
Telephone Number:	
Policy Number:	
Effective date of plan:	
Is this Plan Medicaid? (Check One):	<input type="checkbox"/> Yes <input type="checkbox"/> No

Member Signature: _____ Date: _____

Completed form and submit to Wellfleet via mail, fax or email:

Wellfleet Group, LLC | PO Box 15369 | Springfield, MA 01115-5369

Fax: 413-733-4612 | Email:

customerservice@wellfleetinsurance.com

Questions? Please call Customer Service at 877-657-5030