**2024 COORDINATION OF BENEFITS REQUEST FORM**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| ***Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | ***Badge #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | ***FT, PT or RT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | ***Anthem ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |

Each year the SMART-MTA Trust Fund needs to obtain updated information to avoid a delay in the payment of claims. Please provide the following information so that we may update our records.

1. Please provide your marital status. Single \_\_\_\_\_ Married \_\_\_\_\_\_ Divorced \_\_\_\_\_\_\_

1. Name of Spouse/Legal Domestic Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are they employed? YES \_\_\_ NO \_\_\_

If yes, name of employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: ACTIVE \_\_\_\_\_ RETIRED \_\_\_\_\_ COBRA \_\_\_\_\_

1. Is your spouse/legal domestic partner covered under an insurance plan through his/her

employer?

YES \_\_ NO \_\_ If yes, please complete the following information:

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address / Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List names of all family members covered under the spouse/legal domestic partner’s plan:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Coverage: MEDICAL \_\_\_\_\_\_ DENTAL \_\_\_\_\_\_\_ VISION \_\_\_\_\_\_\_\_\_

1. If divorced, are any of the dependent children covered under an insurance plan through the ex-spouse?

YES \_\_\_\_\_ NO \_\_\_\_\_ Is there a divorce decree or a court order for a specific parent to provide health care coverage to the dependent children?  If yes, please provide a copy.

5. Are you an MTA Retiree and an employee covered through another group policy? YES \_\_\_ NO \_\_\_\_

If yes, please complete the following information:

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are you and/or your dependents covered under a Medicare policy? YES \_\_\_\_ NO \_\_\_\_\_

If yes, provide the person’s name, attach a copy of the card and see the *“Explanation of Hospital Medical Surgical Benefits booklet”* for additional information. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of Medicare Part A: \_\_\_\_\_\_\_\_\_Effective Date of Medicare Part B: \_\_\_\_\_\_\_\_\_

Medicare Entitlement: □ Age □ Disability\* □ End Stage Renal Disease (ESRD) \*Other \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st Date of Dialysis for ESRD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please return this form within 5 business days. If you have any questions regarding the completion of this form, you may contact the SMART-MTA Trust Fund Claims Department at (626) 962-1762 or (213) 624-6487.***

**I certify** that the information provided here is accurate, true and correct.  **I understand** that if the information provided is inaccurate or a misrepresentation, my benefits and my dependents’ benefits may be revoked and/or denied.  Should my benefits and my dependents’ benefits be revoked and/or denied, **I understand** that I may be financially responsible for the full cost of any or all claims submitted.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

Internal use only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EE |  | P S | M | Y / N |
| SP |  | P S | M | Y / N |
| CH |  | P S | M | Y / N |

P- primary S- secondary M-Medicare

Updated COB/Medicare Field Y / N?

Initial \_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15999 Cypress Ave ● Irwindale, CA 91706

(626) 962-1762 ● (213) 624-6487 ● FAX (626) 962-5166