SMART - MTA Trust Fund

2026 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 _____

2. Name of Spouse/Legal Domestic Partner: _____

   Are they employed? YES ___ NO ___

   If yes, name of employer: _____

   Employment Status: ACTIVE _____ RETIRED _____ COBRA _____

3. 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. _____

   4. _____ 5. _____ 6. _____

   Type of Coverage: MEDICAL _____ DENTAL _____ VISION _____

4. 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