



Coordination of Benefits (COB) Questionnaire

It is important that you complete and return this document. COB is a way to coordinate benefit payments when you or your dependents are covered by more than one health plan. By keeping us informed, we can update your records and provide you with timely and accurate claims processing. If we do not have your complete and accurate COB information, the processing of your claims may be delayed. Please answer all questions completely. Thank you for your cooperation.

Are you, your spouse, or any of your dependents who are covered by your health plan, also covered by any other health plan or Medicare? Yes No

If yes: If you have other health insurance plans, please complete sections 1 & 2.

If you have Medicare coverage, please complete sections 1 & 3.

If you have other health insurance plans and Medicare, complete sections 1, 2 & 3.

If no: Please complete and sign section 1 only.

Please return this form in the self-addressed stamped envelope, via fax at **808-535-8302**, or email us at **CustomerService@hmaa.com**. If you have any questions, please call us at **808-941-4622** or toll-free at **888-941-4622**.

SECTION 1 – TO BE COMPLETED BY ALL SUBSCRIBERS

Subscriber's Name	Birth Date	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Date of Retirement (if applicable)
Member Number		Phone Number	
I certify that the information furnished by me on this form is true and correct at this time, and agree to inform HMAA of any changes.			
Subscriber's Signature:		Today's Date:	

SECTION 2 – OTHER COVERAGE INFORMATION

Name of Policyholder	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Relationship to You	
Name and Group Number of Other Health Plan			Policyholder Identification Number	
Other Health Plan's Address			Phone Number	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired			Date of Retirement (if applicable)	
Employer's Name				
Type of Coverage	<input type="checkbox"/> Medical	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
Effective Date				
Cancellation Date				
Please list any other dependents covered by this other plan. If there are more than four, please check this box <input type="checkbox"/> and list the rest on the back of this form.				
1. Name (First and Last)	Relationship to You	3. Name (First and Last)	Relationship to You	
2. Name (First and Last)	Relationship to You	4. Name (First and Last)	Relationship to You	

SECTION 3 – MEDICARE COVERAGE INFORMATION

Name of Medicare Beneficiary _____	Medicare Number _____	
Type of Coverage Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____		Medicare Eligibility Due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease Initial Dialysis Date: _____