HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

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 **941-4622** or toll-free at **888-941-4622.**

SECTION 1 – TO BE COMPLETED BY ALL SUBSCRIBERS

Subscriber's Name	Birth Date	Employment Status ❑ Active ❑ 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 ❑M ❑ 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 ❑Active ❑Retired	Date of Retirement (if applicable)
Employer's Name	

Type of Coverage ❑ Medical ❑ Drug ❑ Dental ❑ 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 ❑ 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:
□ Age
□ Disability
□ End-Stage Renal Disease
Initial Dialysis Date: _____