



COORDINATION OF BENEFITS/MEDICAL RELEASE AUTHORIZATION

Employee Information:

Social Security Number	Employee Name (Last, First, Middle Initial)	Date of Birth
Home Address		
City	State	ZIP Code

Coordination of Benefits:

Is Spouse or Dependent Employed? Yes No

Is Spouse or Dependent Retired? Yes No

If answer is Yes, give Social Security Number: _____

Does Spouse/Dependent have other health insurance? Yes No

If yes, Spouse/Dependent Name with other Health Insurance _____

Spouse/Dependent Employer or Former Employer Name and Address _____

Name/Address and Phone Number of other Health Insurance Carrier _____

Group Policy ID Number(s) of other Health Insurance Carrier _____

Certification: I hereby certify that the information I have provided on this form is true and accurate. In the event any information is false or misleading, the plan administrator or employer may take appropriate action. In the event benefit payments are incorrectly or improperly made, I shall be fully responsible for repayment to the Plan of all costs, fees and expenses related to such improper or incorrect benefit payment, including a reduction in future payment of claims by the full amount of such improper or incorrect benefit payments.

Authorization: I authorize Horizon Blue Cross and Blue Shield to obtain any and all medical records and information from providers of service and/or hospitals, relating to myself and my eligible dependents, to the extent required for the administration of the Plan.

Employee Signature	Work Telephone	Date
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For Assistance Call 1-800-355-2583