CBA, Inc.

Cooperative Benefit Administrators, Inc.
P.O. Box 6249 · Lincoln, Nebraska 68506

COORDINATION OF BENEFITS

In order to complete our annual update of records, please answer the following questions and return this letter to our office.

Member First Name

Member SSN ___ - ___ - ____

Member Last Name

Co-op REA Number

☐ YES ☐ NO Are you or any family member employed outside the Co-op?
If YES, provide the following information:

Name	Relationship	Employer	Phone Number
			– –
			– –

☐ YES ☐ NO Are you or any family member covered under another group plan, other than an NRECA plan?
If YES, provide the following information:

Insurance Company 1:

Company Name	Address, City, State, Zip	Phone Number
		– –

Insured's Name	Date of Birth	Coverage Type	Effective Date	Group No.
	/ /	☐ Medical ☐ Dental ☐ Vision	/ /	

Insurance Company 2:

Company Name	Address, City, State, Zip	Phone Number
		– –

Insured's Name	Date of Birth	Coverage Type	Effective Date	Group No.
	/ /	☐ Medical ☐ Dental ☐ Vision	/ /	

☐ YES ☐ NO Does the coverage include dependents?

Please include a front and back copy of your medical ID card for your other insurance/benefit plan.

Thank you for providing this information. It will assist us in processing your claims accurately and timely.
The completed letter should be mailed to CBA, PO Box 6249, Lincoln, NE 68506.

Signature

Date ___ / ___ / ____

12/05/2005

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CBA, Inc.
Cooperative Benefit Administrators, Inc.
P.O. Box 6249, Lincoln, Nebraska 68506
Phone (402) 483-9200

To:

Member Number:

Member Name:

Patient Name:

REA/Group#

We have received a request for benefits for the above patient. In order for us to update our records, we need the following information:

What is the relationship of this child to the member? _____

Please indicate whether natural parents are:

- ☐ Divorced/Legally Separated
- ☐ Never Married
- ☐ Deceased

If so, who has custody? _____

Please give name of parent without custody and his or her employer.

_____

Natural mother's date of birth: _____

Natural father's date of birth: _____

Does a divorce decree/court order exist? _____ Please forward a copy.

Is the child covered by any other insurance? _____

If yes, please list the name and address of the other carrier(s). _____

_____

Are there other siblings that would have the same status? _____

This information allows us to update the dependent's relationship to our member and coordinate with other coverage that may be primary.

If the requested information is not received within 45 calendar days from receipt of this request, benefits may be denied due to insufficient information. If you have any questions, please return this letter with your inquiry.

Date: