## 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				
METHOD FISCINATIO				
			-	
Member Last Name	•	Co-op REA Number		
☐ YES ☐ NO Are you or any family member employed outside the Co-op?				
	S, provide the following informat			
Name	Relationship	Employer	Phone Number	
			_	
Name	Relationship	Employer	Phone Number	
DVEC DNO Area				
☐ 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, Cit	v. State, Zip	Phone Number	
, ,		,,,		
	Cove	erage Type		
Incured's Name	Г] Medical Г	erage Type / / Dental	, Court No	
Insured's Name			ate Group No.	
Insured's Name Insurance Company 2:	Г] Medical Г	Dental Disjon	ate Group No.	
Insurance Company 2:	Г] Medical Г	Dental Disjon	ate Group No.	
	Г] Medical Г	Dental Vision Fffective Da	ate Group No.   Phone Number	
Insurance Company 2:	Date of Birth  Address, City	Dental Vision Fffective Da		
Insurance Company 2:	Date of Birth  Address, City	Dental Vision Effective Da	Phone Number	
Insurance Company 2:  Company Name	Date of Birth  Address, City  Cove	Dental Vision / / Effective Da	Phone Number	
Company Name Insured's Name	Date of Birth  Address, City  Cove	Dental Vision / /  Effective Da  /, State, Zip  erage Type / / Dental Vision Effective Da	Phone Number	
Insurance Company 2:  Company Name  Insured's Name	Date of Birth  Address, City  Cove	Dental Vision / /  Effective Da  /, State, Zip  erage Type / / Dental Vision Effective Da	Phone Number	
Company Name Insured's Name	Date of Birth  Address, City  Cove  Date of Birth  Medical  the coverage include dependen	Dental Vision / /  Effective Da  /, State, Zip  erage Type / / Dental Vision Effective Da	Phone Number  A Group No.	
Company Name  Insured's Name  YES NO Does  Please include a front and by	Date of Birth  Address, City  Cove  Medical  Medical  the coverage include dependen  Dack copy of your medical ID car	Dental Vision / /  Effective Da  /, State, Zip  erage Type / / Dental Vision Effective Da  ts?  d for your other insurance/benefi	Phone Number  The Group No.  t plan.	
Insurance Company 2:  Company Name  Insured's Name  Does  Please include a front and by the company Name	Date of Birth  Address, City  Cove  Medical  Medical  the coverage include dependen  Dack copy of your medical ID car	Dental Vision / / Effective Da  or, State, Zip  orage Type / / Dental Vision Effective Da  ts?  d for your other insurance/beneficerocessing your claims accurately	Phone Number  The Group No.  t plan.	
Insurance Company 2:  Company Name  Insured's Name  YES NO Does  Please include a front and by  Thank you for providing this	Date of Birth  Address, City  Cove  Medical  Medical  the coverage include dependen  Dack copy of your medical ID car  information. It will assist us in g	Dental Vision / / Effective Da  or, State, Zip  orage Type / / Dental Vision Effective Da  ts?  d for your other insurance/beneficerocessing your claims accurately	Phone Number  The Group No.  t plan.	
Insurance Company 2:  Company Name  Insured's Name  Does  Please include a front and by  Thank you for providing this	Date of Birth  Address, City  Cove  Medical  Medical  the coverage include dependen  Dack copy of your medical ID car  information. It will assist us in g	Dental Vision / / Effective Da  or, State, Zip  orage Type / / Dental Vision Effective Da  ts?  d for your other insurance/beneficerocessing your claims accurately	Phone Number  The Group No.  t plan.	
Insurance Company 2:  Company Name  Insured's Name  Does  Please include a front and by the company Name	Date of Birth  Address, City  Cove  Medical  Medical  the coverage include dependen  Dack copy of your medical ID car  information. It will assist us in g	Dental Vision / / Effective Da  or, State, Zip  orage Type / / Dental Vision Effective Da  ts?  d for your other insurance/beneficerocessing your claims accurately	Phone Number  The Group No.  t plan.	
Insurance Company 2:  Company Name  Insured's Name  Does  Please include a front and by  Thank you for providing this	Date of Birth  Address, City  Cove  Medical  Medical  the coverage include dependen  Dack copy of your medical ID car  information. It will assist us in g	Dental Vision / / Effective Da  or, State, Zip  orage Type / / Dental Vision Effective Da  ts?  d for your other insurance/beneficerocessing your claims accurately	Phone Number  The Group No.  t plan.	

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P.O. Box 6249, Lincoln, Nebraska 68506 Phone (402) 483-9200

То:	Member Number:			
	Member Name:			
	Patient Name:			
	REA/Group#			
We have received a request for benefits for the above patient need the following information:	ent. In order for us to update our records, we			
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 undate the dependent's relation	nobin to our momber and accordingts with			

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.