

**PEIA PPB Plan  
Coordination Of Benefits Form**

*In order to keep our records current, it is a PEIA requirement that this questionnaire be completed every 12 months. Please return this questionnaire within 30 days to prevent delays in future claim submissions.*

Policyholder Name \_\_\_\_\_

ID Number \_\_\_\_\_

Address \_\_\_\_\_

Dependents Covered \_\_\_\_\_

1. Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Do you or any of your dependents have other insurance?

**Yes**   **No**   if yes:   **Single**   **Family**

Type of Coverage                    **Medical**   **Rx Drug**   **Dental**   **Vision**   **Hospital**

3. Employee's Name \_\_\_\_\_

4. Please provide the name, address, and effective date of the other insurance

\_\_\_\_\_

if Medicare, please advise and give effective date \_\_\_\_\_

5. Does the other insurance plan use the gender rule or the birthday rule for coordination of benefits?   Gender   Birthday

6. If the other insurance has terminated, please provide the termination date: \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Day Phone \_\_\_\_\_

Please return this completed letter within 30 days for prompt handling. If related claims are received requiring this same information, you will not receive additional requests.

**Mail To:**

**HealthSmart  
P O Box 2451  
Charleston, WV 25332-3262**