Dear Member,

Included in this letter, you will find a **Coordination of Benefits** form requesting information related to other insurance coverage for yourself and your family. Completing this form will prevent delays in processing your claims. A response is required prior to any future claims processing, even if the response is that there is no other insurance coverage. Your cooperation will be greatly appreciated.

Please take a moment to complete the form and return:

- Fax the form to 336-759-1066
- Email your completed form to claims@acsbenefitservices.com

Your rapid response will enable us to process your claims in a timely fashion. Thank you for your assistance

If you have any question regarding this request, please contact our Customer Service at 800-849-5370.

Sincerely,

ACS Benefits Team

Coordination of Benefits Questionnaire

Your plan contains a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and include all family members. If any of the information below changes, please contact ACS immediately.

IF THIS FORM IS NOT RETURNED, CLAIMS MAY BE DENIED UNTIL INFORMATION IS RECEIVED

Please print all Information and check the options: **Employee's ID # (if known)** _____

Employee's name _____ Covered under another group medical, dental or vision plan? ☐ Yes or ☐ No

Spouse's name _____ Covered under another group medical, dental or vision plan? ☐ Yes or ☐ No

Dependent name _____ Covered under another group medical, dental or vision plan? ☐ Yes or ☐ No

Dependent name _____ Covered under another group medical, dental or vision plan? ☐ Yes or ☐ No

Dependent name _____ Covered under another group medical, dental or vision plan? ☐ Yes or ☐ No

Dependent name _____ Covered under another group medical, dental or vision plan? ☐ Yes or ☐ No

Must list all family members. *If other coverage exists, please list in the information below.*

Other Coverage Information:

If multiple coverage exists, please list on a separate sheet of paper.

Policy/Plan Holder's Name _____ Policy Holder's ID Number _____

Date of Birth _____/_____/_____ Policy/Group Number _____ Type of Coverage ☐ Medical ☐ Dental ☐ Vision

Employer Providing Coverage _____ Other Insurance Company _____

Address of Other Insurance Company _____

Phone Number _____ Effective Date of Policy _____/_____/_____ Termination Date _____/_____/_____

Policy Covers (Check one) ☐ Policy Holder Only ☐ Two Persons ☐ Family

Name _____ Relationship to Policy Holder _____

Name _____ Relationship to Policy Holder _____

Name _____ Relationship to Policy Holder _____

If Medicare covers any member, please provide the name and number as well as reason for coverage (age, disability, or End Stage Renal).

Name _____ Number _____

Medicare A or Medicare B or both

Reason for coverage _____

EMPLOYEE'S SIGNATURE _____ Date _____ Daytime Phone Number _____

Please return: ACS Benefit Services | PO Box 2000 | Winston-Salem, NC | 27102-2000
or email the form to claims@acsbenefitservices.com