

Coordination of Benefits



Please Complete all applicable sections below and return this form to: memberservice@mhc.coop or by uploading in your member portal. Mail to: Mountain Health Co-Op PO Box 30311 Salt Lake City, UT 84130.

Questions? Please call our Customer Service team at 800-299-6080. TTY: 711. We accept all relay calls.

Subscriber Information

Group Number _____ Group Name _____ Member ID _____

Last Name _____ First Name _____ MI ____ DOB ____/____/____

Other Coverage

Current other Coverage Information – Do you or any person listed on your plan have other dental, vision, or other health insurance? Yes No If yes, complete the following.

Name(s)	Insurance Carrier	Date of Coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name _____ Policy # _____ Phone # _____	Begin _____ End _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name _____ Policy # _____ Phone # _____	Begin _____ End _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name _____ Policy # _____ Phone # _____	Begin _____ End _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name _____ Policy # _____ Phone # _____	Begin _____ End _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

Medicare

If you or any person on this application have Medicare, indicate the type(s) of coverage:

Part A Part B Part D Person's Name: _____

Original Effective Date ____/____/____ Medicare # _____

Reason for Medicare Eligibility: Age ESRD Disability Dual Eligibility

Medicaid

Name: _____ Original Effective Date ____/____/____ Medicaid # _____

Declaration

I affirm that the answers given in this application are complete and correct.

Signature: _____ Date: _____