KERN LEGACY
Max Choice

COORDINATION OF BENEFITS QUESTIONNAIRE

The Master Plan Document and Plan Description of the KERN LEGACY Max Choice HEALTH PLAN contains a Coordination of Benefits (COB) provision. COB is a process regulated by law that determines financial responsibility of payment of covered expenses when an individual is covered by two or more group health plans. We depend upon your help in order for us to process your claims correctly and appreciate your prompt reply in completing the below questionnaire.

IMPORTANT NOTICE: Your claims may have been pended for processing**. Even if you have no other coverage, your response is required.** Once your response is received, the processing of your claims will resume and any previously pended claims will be reviewed accordingly.

Subscriber Name: _____	**Identification Number:** _____

Do you and/or a member of your family have other health insurance in addition to KERN LEGACY Max Choice HEALTH PLAN? ☐ No ☐ Yes

If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No Other insurance."
If Yes, please complete all the fields below that pertain/ to the member(s) that has the other coverage.

Section A: Other Insurance Company Information (other than Medicare, see Section C to Provide Medicare Coverage Information)
(Please attach additional page(s), if you have more than one other insurance policy.)

Name of Other Health Insurance Company			**Type of Insurance:** ( ) Group Policy ( ) Student Policy ( ) Medicare Supplemental Policy ( ) Other _____
Other Insurance Address, Street, City, Zip			
Type of Policy Coverage: ( ) Single ( ) Employee & Child Only ( ) Children Only ( ) Family ( ) Employee & Spouse ( ) Spouse Only			
Name of Policyholder			**Date of Birth (required)**
Employment Status: ( ) Actively working for the group ( ) Inactive ( ) Retired ( ) Continuation of Coverage/COBRA ( ) Self Employed			**Employees in Group**: ( ) Less than 20 ( ) 20 + ( ) 100 + ( ) Unknown
Other Insurance Policy #	**Group #**	**Policy Effective Date**	**Other Insurance Phone #**

Name of Person(s) Covered by Other Insurance Indicate above:	**Date of Birth**	**Relationship to the Policyholder**	**Is this policy the primary insurance?**
1.			
2.			
3.			
4.			

Section B: Court Order Information

COMPLETE THIS SECTION IF YOU HAVE DEPENDENT CHILDREN AFFECTED BY A DIVORCE, LEGAL SEPARATION, COURT DECREED CUSTODY/GUARDIANSHIP, OR CHILD SUPPORT ORDER:

Does a court decree state who has responsibility for providing health coverage for any dependent? ☐ No ☐ Yes

If yes, please **attach a copy of the court order** and indicate below the person(s) listed to maintain health coverage and their relationship to the child(ren): _____

Child's Name	Custodial Parent(s) Name and Date of Birth	Non-Custodial Parent(s) Name and Date of Birth	Joint Custody Yes/No	Person with whom child lives more than 50% of the time?

Section C: Medicare Information (If this does not apply, check "No" and skip to Section D)

Does the policyholder and/or dependent(s) have Medicare? ☐ No ☐ Yes

Subscriber's Name	Medicare HIC Number	Effective Date / Term Date
Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disease		Part A: _____ _____ Part B: _____ _____
First Date of Disability:	**Date of First Dialysis Treatment:** **Location of Treatment:** ( ) In Home ( ) Dialysis Facility	**Has a transplant been performed?** ☐ **No** ☐ **Yes** **If yes, please provide the date of the transplant:**

Spouse or Dependent Name	Medicare HIC Number	Effective Date / Term Date
Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disability		Part A: _____ _____ Part B: _____ _____
First Date of Disability:	**Date of First Dialysis Treatment:** **Location of Treatment:** ( ) In Home ( ) Dialysis Facility	**Has a transplant been performed?** ☐ **No** ☐ **Yes** **If yes, please provide the date of the transplant:**

Section D: List of enrolled Dependent(s)

Please provide the names of all dependents enrolled on your KERN LEGACY Max Choice HEALTH PLAN and indicate which medical plan is primary and secondary (if applicable) for each dependent below:

First and Last Name	Relation to Subscriber	Date of Birth	Sex F/M	Primary Insurance Company	Secondary Insurance Company

Acknowledgement:

To the best of my knowledge, the information provided is true, accurate, and complete.

Subscriber's Signature: _____ **Date:** _____

Daytime phone number where you can be reached for questions: (_____) _____

Please return the completed signed form by email, fax or US mail:

Member Services: 855-537-6767	**Fax:** 661-616-4889
Mail: HealthEdge Administrators Kern Legacy Max Choice Health Plan PO Box 11210 Bakersfield, CA 93389-1210	**Email:** eligibility@healthedgeinc.com Please use secure or encrypted Email to ensure security and privacy of Protected Health Information (PHI)

NOTE:

If any of the above information in the questionnaire changes, please call Member Services to obtain a new form.

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