SOUTH CENTRAL *Preferred*℠

COORDINATION OF BENEFITS Form – for those covered under this Plan

This form can be completed online at www.scphealth.com OR you can submit this form to our Customer Service Department: at PO Box 2347, York, PA 17405 OR via fax to (717) 755-7190.

Questions: Call us at • (717) 851-6800 or (800) 842-1768.

A. SUBSCRIBER INFORMATION (Please print clearly)

Subscriber (employee) name _____ *Family ID #* _____

Subscriber's Employer _____*Subscriber Phone number* _____

FORM is being completed for, please mark all that apply:

SELF____ SPOUSE____ CHILDREN ____

Are you or your dependents enrolled in other health coverage other than this Plan? This can include Medicare, Medicaid or any other group health coverage.

YES _____ (Complete sections B & C) NO____ (Complete section C)

B. OTHER COVERAGE SECTION – please provide a copy of the other plan's card.

Dependent Name 1: _____ Effective date: _____ Term date: _____
Subscriber Name: _____ *Relationship to the subscriber:* _____
Plan Name: _____*Plan Phone number:* _____
If Medicare, circle reason for eligibility: Age Disability ESRD
Subscriber's date of birth: _____*Family Identification #:*_____ *Coverage Type:*
Medical ____ Dental ____ Vision ____ Retiree ____ COBRA_____

Dependent Name 2: _____ Effective date: _____ Term date: _____
Subscriber Name: _____ *Relationship to the subscriber:* _____
Plan Name: _____*Plan Phone number:* _____
If Medicare, circle reason for eligibility: Age Disability ESRD
Subscriber's date of birth: _____*Family Identification #:*_____ *Coverage Type:*
Medical ____ Dental ____ Vision ____ Retiree ____ COBRA_____

Dependent Name 3: _____ Effective date: _____ Term date: _____
Subscriber Name: _____ *Relationship to the subscriber:* _____
Plan Name: _____*Plan Phone number:* _____
If Medicare, circle reason for eligibility: Age Disability ESRD
Subscriber's date of birth: _____*Family Identification #:*_____ *Coverage Type:*
Medical _____ Dental ____ Vision_____ Retiree _____ COBRA_____

Use the back of this form for more dependents or for further explanation.

C. SUBSCRIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information according to the provisions of the Plan. I also understand that I must notify my employer, in writing, if there are any changes to the information I provided above. Failure to provide complete and accurate information may result in a delay in the processing of benefits.

Printed Name:_____

Signature:_____Date_____

Caution: Any person who knowingly and with intent to defraud any health plan or insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.