



AMERICAN GROUP ADMINISTRATORS, INC.

## COORDINATION OF BENEFITS UPDATE

EMPLOYEE \_\_\_\_\_ GROUP#: \_\_\_\_\_ EMPLOYEE#: \_\_\_\_\_

1. **ARE YOU EMPLOYED ANYWHERE ELSE? YES** \_\_\_\_\_ **NO** \_\_\_\_\_ IF YES, PT? \_\_\_\_\_ FT? \_\_\_\_\_

NAME AND ADDRESS OF SECOND EMPLOYER \_\_\_\_\_

DO YOU HAVE OTHER INSURANCE THROUGH THIS EMPLOYER? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_  
*IF YES, PLEASE COMPLETE BELOW AND PROVIDE COPIES OF IDENTIFICATION CARDS.*

NAME AND ADDRESS OF MEDICAL INS. CARRIER \_\_\_\_\_  
ARE ANY DEPENDENTS ENROLLED IN THIS MEDICAL PLAN? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

IF YES, NAME(S) \_\_\_\_\_

NAME AND ADDRESS OF DENTAL INS. CARRIER \_\_\_\_\_  
ARE ANY DEPENDENTS ENROLLED IN THIS DENTAL PLAN? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

IF YES, NAME(S) \_\_\_\_\_

2. **ARE YOU MARRIED?** \_\_\_\_\_ **DIVORCED?** \_\_\_\_\_ DATE OF? \_\_\_\_\_ IF YOU HAVE BEEN DIVORCED, PLEASE SEND US A COPY OF THE PORTION OF THE COURT PAPERS INDICATING WHO HAS FINANCIAL AND MEDICAL RESPONSIBILITY FOR YOUR DEPENDENT CHILDREN. WE WILL ALSO NEED THE NATURAL PARENT'S NAME, BIRTHDATE & SSN, PLUS THE NAME AND ADDRESS OF THEIR EMPLOYER TO COORDINATE INSURANCE COVERAGE FOR THE CHILDREN

3. **IS YOUR SPOUSE EMPLOYED?** **YES** \_\_\_\_\_ **NO** \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

SSN \_\_\_\_\_ SPOUSE'S DATE OF BIRTH \_\_\_\_\_

NAME AND ADDRESS OF EMPLOYER \_\_\_\_\_

**DOES YOUR SPOUSE HAVE OTHER INSURANCE** **YES** \_\_\_\_\_ **NO** \_\_\_\_\_  
*IF YES, PLEASE COMPLETE BELOW AND PROVIDE COPIES OF IDENTIFICATION CARDS.*

NAME AND ADDRESS OF MEDICAL INS. CARRIER \_\_\_\_\_  
ARE ANY DEPENDENTS ENROLLED IN THIS MEDICAL PLAN? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

IF YES, NAME(S) \_\_\_\_\_

NAME AND ADDRESS OF DENTAL INS. CARRIER \_\_\_\_\_  
ARE ANY DEPENDENTS ENROLLED IN THIS DENTAL PLAN? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

IF YES, NAME(S) \_\_\_\_\_

**IF NO COVERAGE THRU SPOUSE'S EMPLOYER, PLEASE INDICATE 'NONE':** \_\_\_\_\_

4. **ARE ANY OTHER DEPENDENTS EMPLOYED?** **YES** \_\_\_\_\_ **NO** \_\_\_\_\_ IF YES, PT? \_\_\_\_\_ FT? \_\_\_\_\_

NAME \_\_\_\_\_ SSN \_\_\_\_\_

NAME & ADDRESS OF EMPLOYER \_\_\_\_\_

NAME & ADDRESS OF INSURANCE CARRIER \_\_\_\_\_

5. **ARE YOU OR ANY OF YOUR DEPENDENTS RECEIVING MEDICARE?** **YES** \_\_\_\_\_ **NO** \_\_\_\_\_  
*IF YES, PLEASE COMPLETE BELOW AND PROVIDE COPIES OF IDENTIFICATION CARDS*

NAME \_\_\_\_\_ SSN \_\_\_\_\_

6. **ARE ANY DEPENDENTS 19 YEARS OF AGE OR OLDER STUDENTS?** **YES** \_\_\_\_\_ **NO** \_\_\_\_\_ IF YES, PT? \_\_\_\_\_ FT? \_\_\_\_\_

NAME OF STUDENT \_\_\_\_\_

NAME & ADDRESS OF SCHOOL \_\_\_\_\_

IF NOT ALREADY PROVIDED, PLEASE PROVIDE CURRENT SEMESTERS PROOF OF FULL TIME STUDENT STATUS.

SIGNATURE \_\_\_\_\_ SS# \_\_\_\_\_ DATE \_\_\_\_\_

ATTN:

**ATTACH ADDITIONAL SHEETS OF INFORMATION IF NEEDED TO PROVIDE ALL REQUESTED INFORMATION**