COORDINATION OF BENEFITS
DISCLOSURE FORM

Your insurance company requires you to supply the following information **ONLY** if you, your spouse, or dependents are covered by **another group medical insurance plan other than HMO Illinois or Blue Advantage HMO**. This information will be used to coordinate benefits with the other insurance company. Please complete this form and return it to our office:

Eligibility Department
Managed Health Care Associates, Ltd.
2740 W. Foster Ave., Suite 411
Chicago, IL 60625

Medical Coverage for (check all that apply): ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

Policy Number: _____ ☐ Single ☐ Family

_____ _____ _____
Name of Insured Social Security Number Date of Birth

_____ _____
Relationship Employer Name

_____
Name of Insurance Company

_____
Insurance Company Address

_____
Insurance Company Phone Number

Name(s) of Family Members (if covered):

_____
Name of Spouse

_____
Name of Dependent

_____
Name of Dependent

_____
Name of Dependent

_____
Name of Dependent

_____
Name of Dependent