Coordination of Benefits Questionnaire

Aither Health Subscriber Name | Group Number | Aither Health Member ID #

Your Aither Health Benefit Plan contains a Coordination of Benefits (COB) provision. This form is required by Aither Health for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please call the number on your ID card. We appreciate your prompt reply.

Other Insurance

Are you or any other member of this Aither Health policy covered by another medical or dental insurance policy or any other Aither Health policy?

No — *If No, please complete Section D, sign, date, and return this questionnaire to Aither Health via email at enrollment@aitherhealth.com.*

Yes — *If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage. Then, please sign, date, and return this questionnaire to Aither Health via email at enrollment@aitherhealth.com.*

Section A: *If this does not apply, skip to Section B*

Check those that apply: Other Health Insurance | Other Dental Insurance

What type of policy is this? Group | Individual Policy | Student Policy | Medicare Supplemental

Other Insurance Carrier's Name | Phone Number

Address

City | State | Zip Code

Other Insurance Subscriber's Name | Subscriber's Date of Birth

ID Number | Effective Date of Other Insurance | If Cancelled, Cancellation Date

Individual(s) listed on other policy:	*Effective or Cancel Date, if different from Subscriber:*

Section A *(Continued)*

Is the subscriber: Actively working for the group Inactive Retired, retirement date:

On COBRA, which began:

Subscriber's Employer

Employer's Address

City State Zip Code

Section B: Medicare Information. *If this does not apply, skip to Section C.*

Do you or any of your dependents have Medicare? Yes No

Name of person(s) with Medicare Medicare Number, including the alpha character(s)

Effective Date of Medicare Part A Effective Date of Medicare Part B Effective Date of Medicare Part D

Medicare Entitlement: Age Disability * End Stage Renal Disease (ESRD)*

** If the reason is for Disability or ESRD, please provide the following:*

1st Date of Disability 1st Date of Dialysis for ESRD

Was ESRD started in a facility? Yes No Was ESRD started as Self Dialysis or Home Dialysis? Yes No

Has a transplant been performed Yes No If yes, please provide the date of the transplant

Section C: Court Order Information. *If this does not apply, skip to Section D.*

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)? Yes No

List the name(s) of the dependent(s) that this applies to

If yes, who is the person(s) listed to maintain health coverage? What is the relation to the child(ren)?

Who has custody of the child(ren) more than 50% of the time

Documentation of the court order may be requested from your Aither Health plan.

Section D: Name(s) of Dependent(s) on Aither Health Policy

Name	*Relationship*	*Date of Birth*	*Sex*	*Social Security # (Optional)*

Print Name

Subscriber Signature

Date

Once complete, please send form to Aither at:

Email: enrollment@aitherhealth.com

If you have any questions, call: 833.408.4080