

# CO-ORDINATION OF BENEFITS

## INSTRUCTIONS

1. Please print clearly.
2. Please complete Part 1 & Part 2
3. The declaration must be signed and dated.
4. Please forward completed forms to your Employer.

## PART 1. - EMPLOYEE/MEMBER INFORMATION

Employee/Member's Name \_\_\_\_\_

Group Policy No. \_\_\_\_\_ Account No. \_\_\_\_\_ PID No. \_\_\_\_\_

## PART 2. - CO-ORDINATION OF BENEFITS INFORMATION

The following coverage(s) are eligible for benefits from another source or company. *Please check one of the following:*

- Extended Health Care and Dental Coverage
- Extended Health Care Coverage ONLY
- Dental Coverage ONLY

The following individuals are eligible for the above (please check all applicable individuals):

- Employee
- Spouse
- 1<sup>st</sup> Child
- 2<sup>nd</sup> Child
- 3<sup>rd</sup> Child
- 4<sup>th</sup> Child

In the event of separation or divorce and the dependent children are eligible for benefits from another source or company, the following information is required:

Name of Parent with custody of the children: \_\_\_\_\_

Name of ex-spouse: \_\_\_\_\_

Date of Birth of ex-spouse: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

## DECLARATION

I hereby certify that the above information is true and complete.

Employee/Member's Signature **X** \_\_\_\_\_ Date **X** \_\_\_\_\_