Trustmark Group Insurance
P.O. Box 7904
Lake Forest, Illinois 60045
800-351-2526

Coordination of Benefits

Member's Name: _____ Social Security or Member ID: _____

Member's Address: _____

Group Name & Plan Number: _____

Please answer the following questions and return your completed form to the above address. We require updated information concerning other group coverage on an annual basis. Please notify us immediately if information changes.

1. Please furnish the following information on any family member who has other insurance including Medicare.

   Name of Insured: _____ SSN#: _____

   Insured's Date of Birth: _____

   Carrier or Policy Number: _____

   Name of other insurance carrier: _____

   Phone number of other insurance carrier: _____

2. Type of Coverage (select all that apply):

   ____Medical ____Dental ____Vision ____ Medicaid ____Medicare

3. Plan Coverage (select all that apply):

   ____Individual ____Member Only ____Member/Spouse ____Member/Child(ren) ____ Member/Family

4. Please list the individuals under the plan and their relationship to the insured.

   Name: _____ Relationship: _____ Effective Date: _____

   Name: _____ Relationship: _____ Effective Date: _____

   Name: _____ Relationship: _____ Effective Date: _____

   Name: _____ Relationship: _____ Effective Date: _____

   Name: _____ Relationship: _____ Effective Date: _____

☐ I certify that the information contained on this form is true and complete to the best of my knowledge. (Always required)

☐ I certify that if enrolled under the PPO with HRA medical plan, I will only seek reimbursement for eligible medical expenses as described under the plan, that have not been reimbursed or eligible for reimbursement under any other health plan, other insurance or from any other source. (Only required when enrolled in a Health Reimbursement Arrangement)

I understand, that if enrolled in a Health Reimbursement Arrangement (HRA), reimbursement is made only on eligible medical expenses as described under the plan which are not reimbursable from another medical plan, other insurance, or any other source. I recognize that I am responsible for refunding my Employer's Plan and may be liable for payment of all related taxes including federal, state, or city income tax, should any HRA REIMBURSEMENTS be made on non-eligible expenses as a result of any incomplete information provided, inaccurate answers, or non-timely updates of other coverage. Should you, your spouse, or eligible dependents obtain secondary medical coverage with another carrier after completion of this form, or encounter changes to any of the above information, you must contact Healthy Foundations at (800) 285-7911 to document this information.

_____ _____

Signature Date