J.P. FARLEY CORPORATION
WE HAVE A BETTER PLAN.

P.O. Box 458022 • Westlake, Ohio 44145
Toll Free: 800.634.0173 • **Fax:** 440.250.4301
benefits@jpfarley.com • **www.JPFarley.com**

COORDINATION OF BENEFITS FORM

MUST BE COMPLETED IN FULL

Employer	Branch Location	Group Number
Employee's Last Name	First M.I.	Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female
Home Address	Street ☐ Check here if new	Social Security Number (000-00-0000)
City	State Zip	If Name Change, Give Former Name
Home Phone ( ) -	Work Phone ( ) -	Email Address

The Coordination of Benefits (COB) form must be completed so that J.P. Farley can properly coordinate benefits, to verify whether you and or your dependents have other health insurance coverage. Please return to avoid potential denial of any claims awaiting COB information.

Is your spouse employed? ☐ Yes ☐ No If yes, is the work: ☐ Full Time ☐ Part Time

Is health insurance coverage offered through an employer for any of your dependents, including your children over age 19? ☐ Yes ☐ No

Does anyone have other insurance coverage? ☐ Yes ☐ No
If yes, please indicate: ☐ Medical ☐ Dental ☐ Vision ☐ Rx
☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C ☐ Medicare Part D

Is this plan a high deductible health plan with a Health Savings Account? ☐ Yes ☐ No

Name of person(s) covered under other health plan(s):

Date of birth of the member who carries the other insurance (MM/DD/YYYY):	Effective date (MM/DD/YYYY):	Termination date (MM/DD/YYYY):
Other Group Policy Insurance Company Name:	Policy Number / ID / SSN:	
Insurance Company's Address: City	State Zip	Phone Number: ( ) -
Date eligible for Medicare (MM/DD/YYYY):	Medicare ID#	

If you have children and are legally separated or divorced:
Is there a court decree stating financial responsibility? ☐ Yes ☐ No
If yes, who has responsibility? Who has custody of the child(ren)?

Does anyone other than the natural parents (step-parents) carry insurance on the dependent(s)? ☐ Yes ☐ No	If yes, please provide the Name of the Policyholder:	
Insurance Company's Address: City	State Zip	Phone Number: ( ) -

Policy Number / ID / SSN:

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Return: Completed form to:

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