Luminare Health
PO Box 2920
Clinton, IA 52733-2920

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Orange Ulster School Districts' Health Plan

Coordination of Benefits Letter (COB - Other Insurance)

Subscriber Name:
Subscriber ID #:

Dear

Please complete this questionnaire regarding Other Medical Coverage and respond using the instructions below.

Thank you for your assistance!

Respond using one of the options below:

- **medicalfax1HB@luminarehealth.com**
- **PO Box 2920, Clinton, IA 52733-2920**

Are you or any of your covered dependents **eligible** for insurance coverage in another employer's group plan? ○ Yes ○ No

Are you or any of your covered dependents **enrolled** in another plan through any other source or Medicare? ○ Yes ○ No

Other Medical Coverage Details

Coverage Type: ○ Active ○ Retiree ○ COBRA

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Insurance Name: _____

Coverage Effective Date: _____

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Phone number of
insurance company: _____

Please list all family members currently covered under the other group MEDICAL plan including the policyholder.

Name of person covered	*Relationship to the policyholder with other coverage*	*Birth date*

Government Coverage Details

Medicaid ○ Yes ○ No
Champus/Tricare ○ Yes ○ No
Medicare Part A ○ Yes ○ No

If "yes" for any of the above, provide the date coverage began: _____

Medicare Part B ○ Yes ○ No

If yes, what is the effective date of coverage? _____

What is the reason for the Medicare Part B coverage? ○ Working aged (over 65) ○ End-Stage Renal Disease ○ Under 65, Totally Disabled

Medicare Part D ○ Yes ○ No

If yes, what is the effective date of coverage? _____

If you have any of these Medicare coverages, please include a copy of your Medicare card when responding to this letter.

Other Required Information:

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Dependent Child Details

Is the dependent covered by your current insurance a child of a divorced or separated parent? ○ Yes ○ No

Is there a document, such as a divorce decree (QMSCO), that states who is responsible for the health care coverage of the child? ○ Yes ○ No

If yes, please include a copy of the portion of the document stating who is responsible for the child's health care coverage and the page with effective date signed by the judge when responding to this letter.

Please indicate who is the custodial parent/legal guardian: _____

Please indicate who maintains the primary residence of the child: _____

Thank you for completing the above information!

Please sign this form and return via email, mail or contacting our customer service team at 866-893-4472
I certify that the above information is true and complete to the best of my knowledge

Signature: _____

Please include any required supporting documentation when responding to this form.