HealthPartners

# DENTAL COORDINATION OF BENEFITS FORM

DENTAL CLAIMS DEPARTMENT
PO BOX 1172
Minneapolis, MN 55440-1172

**Please complete the information below and return this form to HealthPartners. If you have questions regarding the form, please contact Member Services at 952-883-5000 or 800-883-2177.**

The HealthPartners and/or HealthPartners Insurance Company Membership Contract contains a "Coordination of Benefits" provision, which allows HealthPartners and/or HealthPartners Insurance Company to share responsibility of covering dental care expenses with any other company that covers you or your family for medical or dental benefits. When dental care expenses are shared between two or more companies, payment up to 100% of eligible charges may be provided thereby reducing a member's out-of-pocket expenses. In addition to benefiting the individual member, coordination of benefits is beneficial to all members because it avoids duplication of payments, which would result in higher premium rates.

HealthPartners and/or HealthPartners Insurance Company Policyholder (Applicant) Name_____ D.O.B. _____

Daytime Phone (including area code) _____ Employer Name _____

Social Security Number _____ HealthPartners and/or HealthPartners Insurance Company Member Number_____

1. Is any family member covered under a dental insurance other than with HealthPartners and/or HealthPartners Insurance Company? ❑ YES ❑ NO
If YES, complete Section A; if NO, go to question 2.

2. Are you divorced or remarried? ❑ YES ❑ NO
If YES, complete Section B; if NO, sign and return.

## Section A

**Please complete Section A with information about other dental insurance only (do not complete this section if other policy terminates when HealthPartners and/or HealthPartners Insurance Company coverage takes effect):**

Name of family member of Policyholder (Applicant) _____ Date of Birth _____ Social Security Number _____

Family member's Employer Name and Address _____

Employer's Dental Plan Name_____

Address for Submitting Claims _____

**Policy Number** _____ **Effective Date** _____ **Cancellation Date** _____
(must be included)

❑ Single Coverage ❑ Family Coverage

If Family Coverage, list all covered members _____

## Section B

**If you are divorced or remarried with dependents, please provide complete dental insurance information if different from above for all dependents.**

| Dependent | Custodial Parent of person responsible for dependent dental care expenses | Date of birth of person responsible | Plan Name | Plan Address | Policy Number | Policyholder Name |
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**Certification and Signature**

I certify that the above information is true and correct. I authorize the administrator of the above named plan(s) to release information to HealthPartners and/or HealthPartners Insurance Company regarding dental care benefits to which I may be entitled. I understand that the purpose of this release of information is to assure appropriate coordination of benefits of all plans. I authorize the assignment of benefits to the providers of service.

This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand that a photocopy of this authorization shall be valid as the original.

_____ _____ _____
SIGNATURE OF APPLICANT | SPOUSE OR SPOUSAL EQUIVALENT SIGNATURE | DATE

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