BOON-CHAPMAN

FAMILY CLAIM FORM

In accordance with the provisions of your health plan, updated coordination of benefits information is needed annually. Please complete this form in its entirety, sign and date it and return it to our office by mailing it to Boon-Chapman, PO Box 9201, Austin, TX 78766 or via fax at (512) 454-8700. ***Failure to complete and return this form may result in a delay of claim payment.*** If you have questions, please contact our customer service at (800) 252-9653.

1. Group/Employer Name: _____
2. Employee Name: _____ ID / SSN: _____
3. Email: _____ Phone: _____
4. Are **YOU** covered by any other insurance? ☐Yes ☐No
5. If you answered ***YES*** to question 4, please complete the following regarding the **Other Insurance**:
   a. Carrier Name: _____
   b. Carrier Phone #: _____
   c. Policy ID: _____
   d. Coverage Type: ☐Medical ☐Dental ☐Vision
   e. Policy Type: ☐Active ☐Retiree ☐Group ☐Individual ☐Medicare ☐Medicaid
6. Are any of **your family members** covered by other insurance? ☐Yes ☐No
7. If ***NO*** to question 6, ***skip to signature and date***.
8. If you answered ***YES*** to question 6, please complete the following regarding the **Other Insurance**:
   a. Policy Holder's Name: _____
   b. Policy Holder's ID: _____
   c. Policy Holder's Date of Birth: _____
   d. Carrier Name: _____
   e. Carrier Phone #: _____
   f. Policy Effective Date: _____
   g. Policy Type: ☐Active ☐Retiree ☐Group ☐Individual ☐Medicare ☐Medicaid
9. Please complete the following for ***all*** dependents checking each coverage options that applies:

		Covered By Other Insurance?			
	Dependent Name (First, MI, Last)	**Medical**	**Dental**	**Vision**	**None**
1)	_____	☐	☐	☐	☐
2)	_____	☐	☐	☐	☐
3)	_____	☐	☐	☐	☐
4)	_____	☐	☐	☐	☐

Use the reverse side of this paper to list any additional dependents.

I hereby certify that the statements and answers above are complete and true to the best of my knowledge.

Signature: _____ Date: _____