SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

COORDINATION OF BENEFITS (COB) FORM

PLEASE NOTE:

- Submit the completed form and any accompanying documents by mail to the above address (**Attn: Claims Department**), electronically through the secure document submission tool on your **Member Portal** or in-person at our Regina or Saskatoon offices.
- When two or more benefit plans are involved, one plan is considered the primary plan. Coordination of Benefits (COB) — Canadian Life & Health Insurance Association (CLHIA) has established industry guidelines defining how COB is applied. There are various factors that determine the order in which claims are paid.
- Please provide us with the following information so that coordination of benefits will be applied to your health and dental claims and to update your COB records in our system.

A. MEMBER INFORMATION (PLEASE PRINT)

Member Full Name	Date of Birth (YYYY-MM-DD)	Identification Number	
Mailing Address/Box No.	City/Town	Province	Postal Code

B. PARTNER/SPOUSE INFORMATION (PLEASE PRINT)

If you don't have a partner/spouse, skip this section.

First Name	Last Name	Date of Birth (YYYY-MM-DD)

C. OTHER COVERAGE

INSTRUCTIONS:

- **If you or any members on this plan have additional health and dental coverage through other insurance plans,** please provide the details of each in the Plan Details subsections on pages 1 to 3.
- **Should you have remaining dependent children that do not fit in the following Plan Details subsections,** please complete Section D: Other Coverage — Additional Dependents for each applicable plan on page 3.
- **If you have more than four other plans to coordinate,** please complete a second copy of this Coordination of Benefits form and submit both forms and any accompanying documents to Saskatchewan Blue Cross together.

PLAN 1 DETAILS

Policyholder/Employee Full Name: _____ Name of Insurance Carrier: _____

Type of coverage:

- ☐ Group Plan (e.g., employer plan, group-based retirement plan)
- ☐ Student Plan (e.g., unversity/college plan)
- ☐ Individual Plan (e.g., personal plan, personal retirement plan)

Benefits covered (check all that apply):

- ☐ Ambulance
- ☐ Dental
- ☐ Extended Health Benefits
- ☐ Health Spending Account
- ☐ Hospital
- ☐ Prescription Drugs
- ☐ Travel
- ☐ Vision – Eye Exams
- ☐ Vision – Prescription Eyewear

Are there any benefits <u>not</u> covered by this other plan (e.g., massage therapy, orthodontics, etc.)?
If **yes,** *please specify below:*

Members covered on this other plan (please fill out table):

PLAN 1	Full Name (List all covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Policyholder/Employee				
Partner/Spouse				
Dependent				
Dependent				
Dependent				

C. OTHER COVERAGE (CONTINUED)

PLAN 2 DETAILS

Policyholder/Employee Full Name: _____ Name of Insurance Carrier: _____

Type of coverage:

- ☐ Group Plan (e.g., employer plan, group-based retirement plan)
- ☐ Student Plan (e.g., unversity/college plan)
- ☐ Individual Plan (e.g., personal plan, personal retirement plan)

Benefits covered (check all that apply):

- ☐ Ambulance
- ☐ Dental
- ☐ Extended Health Benefits
- ☐ Health Spending Account
- ☐ Hospital
- ☐ Prescription Drugs
- ☐ Travel
- ☐ Vision – Eye Exams
- ☐ Vision – Prescription Eyewear

Are there any benefits <u>not</u> covered by this other plan (e.g., massage therapy, orthodontics, etc.)?
If **yes,** *please specify below:*

Members covered on this other plan (please fill out table):

PLAN 2	Full Name (List all covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Policyholder/Employee				
Partner/Spouse				
Dependent				
Dependent				
Dependent				

PLAN 3 DETAILS

Policyholder/Employee Full Name: _____ Name of Insurance Carrier: _____

Type of coverage:

- ☐ Group Plan (e.g., employer plan, group-based retirement plan)
- ☐ Student Plan (e.g., unversity/college plan)
- ☐ Individual Plan (e.g., personal plan, personal retirement plan)

Benefits covered (check all that apply):

- ☐ Ambulance
- ☐ Dental
- ☐ Extended Health Benefits
- ☐ Health Spending Account
- ☐ Hospital
- ☐ Prescription Drugs
- ☐ Travel
- ☐ Vision – Eye Exams
- ☐ Vision – Prescription Eyewear

Are there any benefits <u>not</u> covered by this other plan (e.g., massage therapy, orthodontics, etc.)?
If **yes,** *please specify below:*

Members covered on this other plan (please fill out table):

PLAN 3	Full Name (List all covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Policyholder/Employee				
Partner/Spouse				
Dependent				
Dependent				
Dependent				

C. OTHER COVERAGE (CONTINUED)

PLAN 4 DETAILS

Policyholder/Employee Full Name: _____ Name of Insurance Carrier: _____

Type of coverage:

- ☐ Group Plan (e.g., employer plan, group-based retirement plan)
- ☐ Student Plan (e.g., unversity/college plan)
- ☐ Individual Plan (e.g., personal plan, personal retirement plan)

Benefits covered (check all that apply):

- ☐ Ambulance
- ☐ Dental
- ☐ Extended Health Benefits
- ☐ Health Spending Account
- ☐ Hospital
- ☐ Prescription Drugs
- ☐ Travel
- ☐ Vision – Eye Exams
- ☐ Vision – Prescription Eyewear

Are there any benefits <u>not</u> covered by this other plan (e.g., massage therapy, orthodontics, etc.)?
If **yes,** *please specify below:*

Members covered on this other plan (please fill out table):

PLAN 4	Full Name (List all covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Policyholder/Employee				
Partner/Spouse				
Dependent				
Dependent				
Dependent				

D. OTHER COVERAGE — ADDITIONAL DEPENDENTS

Ensure you have completed each applicable plan details section on pages 1 to 3 before completing the corresponding supplementary information.

Other plans — Remaining dependent children covered (fill out tables / fields as needed):

PLAN 1	Full Name (Remaining covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Dependent				
Dependent				
PLAN 2	Full Name (List remaining covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Dependent				
Dependent				
PLAN 3	Full Name (List remaining covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Dependent				
Dependent				
PLAN 4	Full Name (List remaining covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Dependent				
Dependent				

COMPLETE ACKNOWLEDGMENT & CONSENT ON PAGE 4.

ACKNOWLEDGMENT & CONSENT

I understand that the personal information I have given, as well as any other personal information currently held or provided in the future by Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its agents may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, and helping to develop and recommend suitable products and services to me.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its agents, may be collected, used, maintained and disclosed for the purposes of administering the terms of my policy or the group policy of which I am an eligible member, underwriting, adjudicating and paying claims, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, helping to develop and recommend suitable products and services to me and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations and/or its authorized agents/brokers, representatives, licensed physicians and/or any other healthcare professionals, practitioners or institutions, life and health insurers and reinsurers, government and regulatory authorities, the member of any benefit plan or policy under which I am a participant and other third parties only when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Saskatchewan Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca/privacy or call 1.800.667.6853.

Name of Member (Print)	Signature of Member	Date (YYYY-MM-DD)