HealthSource Plus
Group Benefits · Administration · Wellness · Retirement

Coordination of Benefits (COB)

HSP Form No.11
ENGLISH_01/01/06

Policy Number(s):

COMPLETE THIS FORM IN BLOCK LETTERS USING INK. FORMS WITH PENCIL WILL NOT BE ACCEPTED

A. Employee Information

Employer's Name:

Employee Division N°:	Employee Unit N°:	Employee Certificate N°:

		Sex	Birth Date		
			D	M	Y
Last Name:					
First Name:		☐ M ☐ F			

B. Spouse Information/Coordination of Benefit

		Sex	Birth Date		
			D	M	Y
Last Name:					
First Name:		☐ M ☐ F			

Does your spouse have access to **health coverage**? ☐ Yes - **Check one:** ☐Family ☐Single ☐Waived

☐ No - **Check one:** ☐Unemployed ☐Coverage not offered by employer

Does your spouse have access to **dental coverage**? ☐ Yes **-** **Check one:** ☐Family ☐Single ☐Waived

☐ No - **Check one:** ☐Unemployed ☐Coverage not offered by employer

Name of Spouse's Employer: _____

C. Employee Authorization

I declare that the statements I have made on this form are true and complete.

I understand that spousal claims are only to be submitted where my spouse is not insured elsewhere or where a portion of the claim is not reimbursed under my spouses plan. I understand that dependent claims should first be submitted to the plan of the parent whose day and month of birth comes earlier in the year, and that only the portion not reimbursed may then be submitted to my plan.

I understand that if I waive benefits now and wish to reinstate my benefits in the future, I will be required to provide at my expense, satisfactory evidence of insurability.

I understand that the above information may be audited and at such time, I may be required to validate the above declarations

I understand that if it is found that I have provided misleading or fraudulent information and / or am unable to validate my declarations on this form that I may be required to reimburse my employer for all spousal and dependent claims retroactive to my hire date, in addition to any costs related directly to the recovery of such funds.

Name (Please Print) Signature Date (dd/mm/yyyy)