Co-ordination of Benefits

Date: ________________________

Group Name: ____________________________________ Group: __________ Division #: _____

Employee: ______________________________________ Certificate #: ___________________

When two or more benefit plans are involved, one plan is considered to be the primary plan. As a Plan Member, your claims should be processed through your RWAM Plan first. Any remaining balances can then be processed through the other insurance plan.

Please provide us with the following information so that co-ordination of benefits will be applied to future Extended Health Care and Dental claims.

Do you or your spouse have group coverage with another carrier? (complete Section A)

Are your eligible dependent children covered by another carrier? (complete Section B)

Co-ordination of benefits (COB)

CLHIA (Canadian Life & Health Insurance Association) has established industry guidelines defining how COB is applied. There are various factors that determine the order in which claims are paid.

Claims for your Spouse

- Your spouse's plan pays first.
- Your RWAM plan pays second.

Claims for Dependent Children

Families with joint or no custody arrangements:

- The plan of the biological parent with the earlier birth date (in the calendar year) pays first.
- The plan of the biological parent with the later birth date pays second.

Families with single/sole custody arrangements:

- The plan of the biological parent with custody of the dependent child pays first.
- The plan of the spouse (if applicable) of the biological parent with custody of the dependent child pays second.
- The plan of the biological parent not having custody of the dependent child pays third.

Post-Secondary Students (University/College)

- Student plans pay before any plan where the student is covered as a dependent.

Section A

Do you or your spouse have group coverage with another carrier?

Extended Health Care

Yes ☐ Name of Insurance Carrier ______________________

Name & Relationship of Policyholder ______________________

Effective Date ______________________

No ☐ Date Coverage Terminated (if applicable) ______________________

Dental

Yes ☐ Name of Insurance Carrier ______________________

Name & Relationship of Policyholder ______________________

Effective Date ______________________

No ☐ Date Coverage Terminated (if applicable) ______________________

Date ______________________ Employee Signature ______________________

Continued…

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Employee Name: ______________________ Certificate #: ______________

Section B

Are your eligible dependent children covered by another carrier?

Name(s) of Dependent(s) ______________________

Type of custody arrangement (if applicable): Joint ☐ Single ☐
(If there is no formal custody arrangement, please indicate joint)

Date of birth of biological parents (yy/mm/dd) Mother __________ Father __________

Extended Health Care

Yes ☐ Name of Insurance Carrier ______________________

Name & Relationship of Policyholder ______________________

Effective Date ______________

No ☐ Date Coverage Terminated (if applicable) ______________________

Dental

Yes ☐ Name of Insurance Carrier ______________________

Name & Relationship of Policyholder ______________________

Effective Date ______________

No ☐ Date Coverage Terminated (if applicable) ______________________

If alternate arrangements exist for additional child(ren), please detail:

Name(s) of Dependent(s) ______________________

Type of custody arrangement (if applicable): Joint ☐ Single ☐
(If there is no formal custody arrangement, please indicate joint)

Date of birth of biological parents (yy/mm/dd) Mother __________ Father __________

Extended Health Care

Yes ☐ Name of Insurance Carrier ______________________

Name & Relationship of Policyholder ______________________

Effective Date ______________

No ☐ Date Coverage Terminated (if applicable) ______________________

Dental

Yes ☐ Name of Insurance Carrier ______________________

Name & Relationship of Policyholder ______________________

Effective Date ______________

No ☐ Date Coverage Terminated (if applicable) ______________________

Date ______________ Employee Signature ______________________

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