CPM, Inc.
1220 SW Executive Drive
Topeka, Kansas 66615
Phone 785-273-8398 - Fax 785-273-6850

Dear Insured:

Your Health Plan contains a coordination of benefits provision which applies when you have more than one health insurance. There are specific laws that mandate the order of payment responsibility for covered services when an individual is covered by more than one Employer Group Health Plan and/or Medicare. CPM, Inc. is required to identify situations where another Employer Group Health Plan and/or Medicare may have paid benefits in error because another group health plan should have been primary payor and to report this information to the Health Care Finance Administration (HCFA) on a periodic basis.
Please provide the following information so we can ensure our records accurately reflect your health care coverage information.

Subscriber Name:	Subscriber CPM, Inc. ID #:	Subscriber Social Security #:

Do you have other insurance? Yes _____ No _____ *If yes complete Section A, if no see page 2*

SECTION A: OTHER INSURANCE COMPANY INFORMATION (Attach additional page(s) if there is more than one other insurance policy.)

Other Insurance Name, Address, Street, City, Zip			
Type of Coverage:( )Single ( )Employee & Child Only ( )Children Only (Family ( )Employee & Spouse ( )Spouse Only			
Name of Policy Holder		Date of Birth	Policyholder's Gender: ( ) Male ( ) Female
Other Insurance Policy #	Group No.	Other Insurance Phone #	Policy Effective Date ____/____/_____
Employees in Group: ( ) Less than 20 ( ) 20 or more ( ) 100 or more ( ) Unknown			

Persons Covered by Other Insurance	Date of Birth	Relationship	Social Security No.
1.			
2.			
3.			
4.			

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SECTION B: COMPLETE THIS SECTION ONLY IF YOU HAVE DEPENDENT CHILDREN AFFECTED BY A DIVORCE, LEGAL SEPARATION, COURT DECREED CUSTODY/GUARDIANSHIP, OR CHILD SUPPORT ORDER.

Does a court decree state who has financial responsibility for providing health coverage for any dependent?

( ) NO ( ) YES, the court decree specifies that_____has responsibility.

Child's Name	Custodial Parent(s) Name and Month/Day of Birth	Non-Custodial Parent(s) Name and Month/Day of Birth	Joint Custody Yes/No	Person with whom child lives

Provide a copy of the insurance card for each policy that covers the dependents listed above.

SECTION C: MEDICARE COVERAGE Complete only if a member or dependent is covered under Medicare

Subscriber's Name	Sex	Medicare HIC Number	Effective Date Term Date
	( ) Male ( ) Female		Part A _____ _____ Part B _____ _____
Location of Treatment: ( ) In Home ( ) Dialysis Facility	Date of First Dialysis Treatment:		Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disability

Spouse or Dependent	Sex	Medicare HIC Number	Effective Date Term Date
	( ) Male ( ) Female		Part A _____ _____ Part B _____ _____
Location of Treatment: ( ) In Home ( ) Dialysis Facility	Date of First Dialysis Treatment:		Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disability

SECTION D: This section must be completed and signed by the subscriber.

To the best of my knowledge the information provided is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, or any other insurance carrier or plan to make available to Corporate Plan Management all information concerning claims filed by me or on my behalf.

Subscriber's Signature	Date of Birth	Work Phone No.	Home Phone No.	Today's Date