INDECS CORPORATION

COB Questionnaire

(Please answer all questions completely)

Date Sent:

Section	Details
Subscriber Information	Name of Subscriber: ____ Member ID#: ____
Current Marriage Status	☐ Single ☐ Married ☐ Legally separated* ☐ Divorced* **If legally separated (by court decree) or divorced, please complete section below entitled "Divorced/Separated Parents.*
Spouse Information	Name of Spouse: ____ Spouse's Employer: ____ Spouse's Date of Birth: ____ Spouse's Social Security #: ____ Is Spouse covered by any other health insurance? Yes ☐ ☐ No ***If yes, please complete the following:*** Is Spouse covered by Medicare? Yes ☐ ☐ No Is Spouse covered by Medicare PartD? Yes ☐ ☐ No Name and address of other Insurance Company: ____ Policy #: ____ Effective Date of Coverage: ____ Has spouse been covered under any other coverage in the past 12 months that was terminated? ☐ Yes ☐ No If yes, term date: ____
Dependent Children Information	Are any of your dependent children covered by other health insurance? ☐ Yes ☐ No ***If yes, please list all children so covered.*** Name of other Insurance Company: ____ Policy #: ____ Effective Date of Coverage: ____ Name of Policyholder: ____ Children's Name(s) ____ Date of Birth: ____ ____ Date of Birth: ____ ____ Date of Birth: ____ ____ Date of Birth: ____
Divorced/ Separated Parents	Effective Date of Divorce: ____ ; or Legal Separation ____ *Please check one:* ☐ There is a court order* assigning responsibility for the children's medical expenses to my health care plan. ☐ There is a court order* assigning responsibility for the children's medical expenses to my Spouse's/Ex-Spouse's health care plan. ☐ There is no court order assigning responsibility for the children's medical expenses. **Please attach a copy of your separation agreement/divorce decree.*
Please sign & date	*I certify that all information provided is correct, knowing that providing false or misleading information is punishable under the law:* Signature of Subscriber: ____ Date ____