COORDINATION OF BENEFITS

Subscriber ID	*Subscriber Phone Number*
Subscriber Name	*Subscriber Date of Birth*

OTHER COVERAGE

Do you, your spouse/domestic partner or children have coverage **Other than Advantek?** ❑ Yes ❑ No

- If **No,** please skip all sections, sign, date and fax to **559-244-0458** or email to **eligibility@advantekbenefit.com**
- If **Yes,** please complete the following sections as applicable. **Important:** *Please provide a copy of the ID card*

Other Subscriber Name:		Other Subscriber Date of Birth:	
Medical Carrier	ID #	Group #	Effective Date
Dental Carrier	ID #	Group #	Effective Date
Vision Carrier	ID #	Group #	Effective Date

Important: Please complete for each covered dependent that has ***Other Coverage.*** Use a separate page if needed for additional dependents.		Medical	Dental	Vision
		Covered?	Covered?	Covered?
Spouse / Domestic Partner Name	Date of Birth	Yes No	Yes No	Yes No
Child #1 Name	Date of Birth	Yes No	Yes No	Yes No
Child #2 Name	Date of Birth	Yes No	Yes No	Yes No
Child #3 Name	Date of Birth	Yes No	Yes No	Yes No

CHILD COVERED UNDER MORE THAN ONE PLAN

Please complete this section if you are divorced, separated or not living with your child(ren)'s other parent

Please provide information on the Biological Parent of your child(ren). **Use a separate page if necessary.**

Bio-Parent Name:____Date of Birth:_______________________

Does this parent have other insurance for the child(ren)? ❑ Yes (provide details under **"Other Coverage"** above) ❑ No

Is there a Court Order specifying legal requirements for health insurance for any of the covered children? ❑ Yes ❑ No

- If **No**, there is no Court Order regarding healthcare, who do the child(ren) primarily reside with?__________________
- If **Yes**, please provide a copy of the Court Order which pertains to ***health insurance only***.

MEDICARE INFORMATION

If this does not apply, skip this section

Does any member and/or dependent have Medicare? ❑ Yes ❑ No

- If No, skip to Member Signature section, sign, date and return.
- If Yes, complete the below information.

Name of Person with Medicare:	Medicare ID Number:
Effective Date of Medicare Part A:	Effective Date of Medicare Part B:

Medicare Due to Age?	❑ Yes ❑ No	Medicare Due to Disability?	❑ Yes ❑ No	1st Date of Disability:
Medicare Due to End Stage Renal Disease? (ESRD)	❑ Yes ❑ No	1st Date of Dialysis	Was ESRD started in a facility? ❑ Yes ❑ No	Was ESRD started as Home Dialysis? ❑ Yes ❑ No
Has a Transplant been performed? ❑ Yes ❑ No			If yes, please provide date of transplant:	

SUBSCRIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information to Advantek Benefit Administrators in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits.

Subscriber Name (Print)	*Subscriber Signature*	*Date*

If you need assistance completing this form, contact Advantek Benefit Administrators at **866-556-7655**.
Return form by **Fax** to **559-244-0458**; by **Email** to eligibility@advantekbenefit.com;
Or by **Mail** to: PO Box 45007, Fresno CA 93718