FOUNDATION FOR MEDICAL CARE
OF TULARE & KINGS COUNTIES, INC.

Date:
Subscriber ID:
Subscriber Name:

Annual Request

Subscriber Name:
Address: Benefit Option:
City,State Zip:

RE: Coordination of Benefits Inquiry for other health insurance coverage other than Kaweah Delta for spouse and/or dependent(s)

Dear Insured:

All plans require Coordination of Benefits (COB) when another carrier is involved. This questionnaire will help us determine if we should coordinate benefits with another insurance company. Please answer all questions that apply to ensure Foundation has the most updated information:

1. As of 2022, Is the member or dependents covered by another group, accident, or Health Insurance:

   Dependents: _____ _____ _____
   _____ _____ _____

   ◯ No ◯ Yes Effective Date: _____ mm/dd/yy

   a. If **"No"** please sign, date, and return to Foundation
   b. If **"Yes"** complete questions 2-5; sign, date, and return via:

      a. Email COB letter to kaweahcobform@tkfmc.org
      b. Fax COB letter to 559-334-0081
      c. Mail back to 3335 S Fairway Visalia, CA 93277

Note: If dependents do not have other coverage members can call via confidential Voicemail Number 559-802-1995 and follow the instructions.

* If members are covered under Medi-Cal please follow the no other insurance instructions as the Group Health Plan will be primary.

2. Is the other group insurance plan ◯ Single or ◯ Family Coverage.

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3. If family coverage, please confirm all covered family members and their effective date(s) on the plan.

- _____
- _____
- _____
- _____
- _____
- _____

ID Number: _____ Group Number: _____
Other Health Insurance Company:_____
Address: _____
City/State/Zip:_____ Phone Number:_____

4. If parents are separated or divorced, does the other natural parent, with custody, carry insurance for the dependent(s)? ◯ No ◯ Yes If yes, complete the below section:

Subscribers Name:_____ Date of Birth: _____
ID Number: _____ Group Number: _____
Health Insurance Company: _____
Address: _____
City/State/Zip:_____ Phone Number: _____

5. Has there been a court decree issued regarding insurance coverage? ◯ No ◯ Yes
If yes, please explain: _____

Step-parent Information Only
If the parents are divorced, is the custodial parent married? ◯ No ◯ Yes
If yes, complete stepparents insurance information below:
Subscriber Name: _____
Health Insurance Name: _____
Address: _____
City/State/Zip:_____ Phone Number:_____

I hereby attest that the information on this form is true and accurate.

Name of individual completing the form: _____
Signature: Date: _____

_____
Phone Number: _____

Note: Claims will be denied until COB confirmation is received by Foundation.

Thank you for your assistance and continued service to our community. If you have any questions, please call Customer Service at 1-800-662- 5502 or (559) 734-1321 Option 3.