9777 Las Vegas Blvd South Las Vegas NV 89183 (702) 797-8940

ORDER OF BENEFITS DETERMINATION

Employee Name: _____

Dependent Name: _____

The National Association of Insurance Commissioners has approved a change in the Coordination of Benefits (COB) guidelines as it relates to insured dependents of divorced or separated parent s.

The order of benefits determination previously followed for children of divorced or separated parents called for the group health plan of the male parent to determine the benefits before the plan of the mother (it followed father, step-father, then mother). To avoid possible criticism on the basis of sex discrimination, the guidelines for the order were changed to the following:

A. If a court decree has determined financial responsibility for a child's health care expenses, the plan of the parent having the responsibility pays first.

B. If no court decree determined financial responsibility for the child's health care expenses, the plan of the parent with custody pays before the plan of the other parent.

C. The plan of the stepparent married to the parent with custody of the child pays before the plan of the parent not having custody.

This office requires you to answer the following questions before we can process your claim.

1 What is the relationship of the employee to the above named dependent? _____
2 Is there a court decree that determines financial responsibility for the child's health care expenses?

Yes _____ No_____

If the answer is **YES**, please advise the name and address of the parent responsible, the employer and group insurance carrier_____

If the answer is **NO**, please advise the name and address of the parent with custody, the employer and group insurance carrier. _____

3. If the parent with custody is remarried, please advise the name, employer and group insurance carrier of stepparent. _____

The information provided in this form, as well as that contained in the required documentation will remain strictly confidential.

Please read and sign the following certification.

I certify that the information I have supplied herein is true and accurate to the best of my knowledge. Furthermore, I understand that to falsify this or any other insurance document could constitute insurance fraud and may result in disciplinary action up to and including termination of employment.

Date _____ Signature of Employee Printed Name _____