ASR health benefits

HIPAA
Coordination of Benefits and Authorization of PHI Form

Complete this form and return it to:
Attn: Benefits
Kalamazoo College
1200 Academy Street
Kalamazoo, MI 49006
or
HRBenefits@kzoo.edu

Employee Last Name:	Employee First Name:	M.I.:	Date of Birth:
Employer Name:			
Marital Status:	☐ Single	☐ Married	☐ Divorced

COORDINATION OF BENEFITS

Is your spouse employed?		☐ Yes	☐ No
If Yes, provide the name, address, and phone number of your spouse's employer:			
If your spouse is employed, is your spouse eligible for insurance coverage through his or her employer?		☐ Yes	☐ No
If Yes, has your spouse elected coverage under his or her employer's group health care plan?		☐ Yes	☐ No
If Yes, check coverage(s) elected	☐ Medical	☐ Dental	☐ Vision
and provide the carrier's name, address, and policy/group number:			
Is health insurance for any of your dependent children mandated by a divorce decree or child support order?		☐ Yes	☐ No
If Yes, provide the name(s) of the child(ren) whose health insurance coverage is so mandated and send a copy of the decree or order to ASR:			
Who is responsible for providing health insurance coverage for the child(ren) above? Name:			
Date of Birth:			
Relationship to Child(ren) above:	☐ Father	☐ Mother	☐ Other:
Who has physical custody of the child(ren) above?	☐ Father ☐ Mother	☐ Other:	☐ Both
Are you or any dependents covered by any other group insurance plan, HMO, or government plan like Medicare?		☐ Yes	☐ No
If Yes, provide name(s) of all insured persons:			
Is the insured an active employee?		☐ Yes	☐ No
Is the insured a COBRA participant?		☐ Yes	☐ No
If Yes, please attach a copy of the COBRA election form to this form.			
Is the insured a retiree?		☐ Yes	☐ No
Provide the carrier's name, address, and policy/group number of the other coverage:			
What is the effective date of the other coverage?			
What is the termination date of the other coverage (if known)?			

CERTIFICATION

I hereby certify that all of the above information is true to the best of my knowledge and that the dependents listed above are my dependents within the definition contained in the group health Plan of my employer/organization. I agree to notify the plan administrator if and when there is a change in any dependent's status. I hereby request the coverage for which I am eligible under the Plans of my employer/organization, and I authorize same to deduct any required contribution from my earnings/funds. I reserve the right to revoke this authorization at any time upon written notice.

EMPLOYEE SIGNATURE:		DATE:	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing below, as an employee or dependent aged 18 or older, I authorize the use or disclosure of my individually identifiable health information by or to any family members, any health care provider, the Plan Sponsor, the insurer/TPA of the Plan, or any other entity providing services in connection with the Plan in order to process my enrollment in the Plan or to process any claim for my Plan benefits. This authorization is effective until the date I terminate enrollment in the Plan. Further, I have read and I understand the following: (1) I may revoke this authorization at any time before its expiration date by notifying the Plan in writing, but the revocation will not have any effect on the actions the Plan took before it received the revocation; (2) I may see and copy the information described on this authorization if I ask for it; (3) I am not required to sign this authorization in order to receive my health care benefits (enrollment, treatment, or payment); and (4) The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

EMPLOYEE SIGNATURE:		DATE:	
SPOUSE SIGNATURE:		DATE:	
DEPENDENT SIGNATURE:		DATE:	
DEPENDENT SIGNATURE:		DATE:	
DEPENDENT SIGNATURE:		DATE:	