StirlingBenefits™
Evolving the Business of Benefits℠

Please complete the secure online COB form below to help Stirling Benefits, Inc. update our records on the other health coverage you, or your dependents, may have, including Medicare.

By doing so, the plan will be able to apply the proper coordination of benefit provisions to claims as they are submitted, and reduce the time processing your claim(s).

**This form cannot be used to add or remove dependents, or make any other changes. Please submit any other changes directly to your Human Resources Representative. **

Thank you.

Employer Name:

Employee Information:

Employee Name (Last Name, First Name)

Employee Social Security No. (no dashes) or your Alternate ID located on your ID card

E-Mail Address

Phone Number (no characters or dashes)

Are you covered by Medicare?

◯ Yes ◯ No

If yes, please complete the information below. Check all that apply

☐ Part A ☐ Part B ☐ Employed ☐ Retired ☐ Disabled

Medicare Number

Medicare Effective Date

Spouse Information:

Marital Status

◯ Married ◯ Single ◯ Divorced

Spouse's Name (Last Name, First Name)

Does your Spouse have other coverage (not Medicare).

◯ Yes ◯ No

If yes, please indicate type of coverage

☐ Medical ☐ Dental ☐ Both

Effective Date of other coverage

Policy ID#

Is your Spouse covered by Medicare?

◯ Yes ◯ No

If yes, please complete the information below. Check all that apply

☐ Part A ☐ Part B ☐ Employed ☐ Retired ☐ Disabled

Medicare Number

Medicare Effective Date

Dependent Information: *If you have more than 4 dependents, please print this form and submit it to your Human Resources Department by January 1st.

Do ANY of your Dependents have other insurance coverage (including Medicare)

◯ Yes ◯ No ◯ Not applicable

If you answered Yes to "Do any of your Dependents have other insurance coverage (including Medicare)", please complete the information below:

Dependent 1

Does this Dependent have other insurance (not Medicare).

◯ Yes ◯ No

Dependent Name

If this Dependent has other coverage, please indicate type of other coverage below:

☐ Medical ☐ Dental ☐ Both

If a natural parent or ex-spouse covers this dependent, are they primary due to court order or other reason?

◯ Yes ◯ No

If another coverage is primary for this dependent, please complete the information below:

Policy Holder's Name

Policy Number

Effective Date of other policy

Is this Dependent covered by Medicare?

◯ Yes ◯ No

If yes, please complete the information below. Check all that apply

☐ Part A ☐ Part B ☐ Employed ☐ Disabled

Medicare Number

Medicare Effective Date

Dependent 2

Does Dependent 2 have other insurance (not Medicare).

◯ Yes ◯ No

Dependent Name

If this Dependent has other coverage, please indicate type of other coverage below:

☐ Medical ☐ Dental ☐ Both

If a natural parent or ex-spouse covers Dependent 2, are they primary due to court order or other reason?

◯ Yes ◯ No

If another coverage is primary for this dependent, please complete the information below:

Policy Holder's Name

Policy Number

Effective Date of other policy

Is Dependent 2 covered by Medicare?

◯ Yes ◯ No

If yes, please complete the information below. Check all that apply

☐ Part A ☐ Part B ☐ Employed ☐ Disabled

Medicare Number

Medicare Effective Date

Dependent 3

Does Dependent 3 have other insurance (not Medicare).

◯ Yes ◯ No

Dependent Name

If this Dependent has other coverage, please indicate type of other coverage below:

☐ Medical ☐ Dental ☐ Both

If a natural parent or ex-spouse covers Dependent 3, are they primary due to court order or other reason?

◯ Yes ◯ No

If another coverage is primary for this dependent, please complete the information below:

Policy Holder's Name

Policy Number

Effective Date of other policy

Is Dependent 3 covered by Medicare?

◯ Yes ◯ No

If yes, please complete the information below. Check all that apply

☐ Part A ☐ Part B ☐ Employed ☐ Disabled

Medicare Number

Medicare Effective Date

Dependent 4

Does Dependent 4 have other insurance (not Medicare).

◯ Yes ◯ No

Dependent Name

If this Dependent has other coverage, please indicate type of other coverage below:

☐ Medical ☐ Dental ☐ Both

If a natural parent or ex-spouse covers Dependent 4, are they primary due to court order or other reason?

◯ Yes ◯ No

If another coverage is primary for this dependent, please complete the information below:

Policy Holder's Name

Policy Number

Effective Date of other policy

Is Dependent 4 covered by Medicare?

◯ Yes ◯ No

If yes, please complete the information below. Check all that apply

☐ Part A ☐ Part B ☐ Employed ☐ Disabled

Medicare Number

Medicare Effective Date

I hereby certify that the above statements are complete and accurate to the best of my knowledge

◯ Agree

Date Completed:

Submit