QBE Insurance

Coordination of Benefits Form

Date
Employee
Claimant

Form instructions and notes: Information must be within 12 months of the claim incurred date. You may complete this section or provide signed documentation from the Employee including this information

Other Coverage / Coordination of Benefits

Does the Claimant have any other health insurance coverage?	◯ Yes ◯ No
Date "Other Coverage" was last verified with the Employee:	
If Yes, please complete the below:	
Name of other insurance carrier:	Effective date of coverage:

Medicare Information

Is the **Employee** covered under Medicare?		◯ Yes ◯ No
A. Part A	◯ Yes ◯ No	Effective date:
B. Part B	◯ Yes ◯ No	Effective date:
C. What is qualifying event?	◯ Disability ◯ ESRD ◯ Age	
Is the **Claimant** covered under Medicare?		◯ Yes ◯ No
A. Part A	◯ Yes ◯ No	Effective date:
B. Part B	◯ Yes ◯ No	Effective date:
Claimant's Medicare Identification Number (From Medicare ID card):		
C. What is the Claimant's Medicare qualifying event?		◯ Disability ◯ ESRD ◯ Age

General Comments

Print name

Title

Authorized Signature

Date

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