TRIBAL
HEALTH PARTNERS T.P.A., L.L.C.

Your Tribal Solution for Complete Self-Funded Benefit Plan Administration

Dear Member,

From time to time, Tribal Health Partners must update our Coordination of Benefits information. "Coordination of Benefits" is the process used to determine how claims will be paid when you or a covered family member has more than one insurance carrier. We need you to provide additional information to make sure that your claims are processed appropriately.

Under the terms of your Plan Document, you are required to share information with us regarding your other insurance carriers so that we can determine our obligations. Please complete the enclosed questionnaire, sign and date and return it within **7 days**.

Thank you for your cooperation. If you have any questions regarding this issue, please call 623-889-7200 or 888-419-6139

Sincerely,

Coordination of Benefits Department

SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Subscriber Name: _____

ID Number: _____

COVERAGE INFORMATION

Please note: if you, your spouse or dependent(s) have:

- Other coverage, please complete section 1, then sign and date the form.
- No other coverage, please complete section 2, then sign and date the form.

1. Other Coverage (list each separately) (including Medicare)

Carrier Name: _____
Carrier Address: _____
Subscriber's Name: _____ Policy #_____Subscriber's SS# _____
Policy Effective Dates: Start_____ End _____ Covered Dependents _____
Coverage type:
(Check applicable) Hospital____ Major Medical____Prescription ____Dental____ Retiree_____ Cobra_____ Other____

2. No Other Coverage

If your spouse does not have other health coverage, please indicate the reason:

Benefits not offered_____ Unemployed_____ Self-employed_____ Waived, as of: _____

Part-time employee (not eligible for benefits) _____

Other, please explain: _____

SUBSCIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information accordance with the Plan Document. Failure to provide complete and accurate information may result in a delay in the processing of claims.

Print Your Name: _____ ID #: _____

Signature: _____ Date: _____