CORESOURCE
*A Trustmark Company*
PERSONAL. FLEXIBLE. TRUSTED.

# COORDINATION OF BENEFITS FORM

**CoreSource**
**P.O. Box 25946**
**Overland Park, KS 66225-5946**
**(913) 685-4740 (800) 990-9058 (913) 681-0886 Fax**

## EMPLOYEE INFORMATION

| Name (First, MI, Last) | Sex ☐ Male ☐ Female | Birthdate | Member Number |
|---|---|---|---|
| | | | |

| Home Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Employer: | Date of Hire | Occupation | Date Last Worked |
|---|---|---|---|
| | | | |

## SPOUSE INFORMATION

| Name (First, MI, Last) | Sex ☐ Male ☐ Female | Birthdate | Soc. Sec. No. |
|---|---|---|---|
| | | | |

| Spouse's Employer Name | Address | Phone No. |
|---|---|---|
| | | |

## OTHER INSURANCE INFORMATION

| Do You or Your Dependents Have Other Coverage? Yes ☐ No ☐ | Type of Coverage? ☐ Single ☐ Family | Type of Plan? ☐ Group Health Plan ☐ Government Plan ☐ Medicare ☐ Other |
|---|---|---|
| | | |

| Name of Person Covered by Other Insurance | Group Number | Soc. Sec. No. | Benefits ☐ Medical ☐ Dental ☐ Vision ☐ Other |
|---|---|---|---|
| | | | |

Name and Address and Phone No. of Other Insurance Company

AUTHORIZATION TO RELEASE INFORMATION --
I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to CoreSource for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR) _____ DATE _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS --
I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR) _____ DATE _____