PALM BEACH COUNTY FireFighters
EMPLOYEE BENEFITS FUND

Name: _____ Last 4 of Social: _____ Station: _____ Shift: _____

Coordination of Benefits
(COB Form)

Dear Participant:

This policy requires us to determine if you and/or members of your family are covered by any other insurance plan other than Palm Beach County Firefighters Employee Benefits Fund. This is completed annually for each covered employee. Please complete this form and return to us ASAP.

Please circle the appropriate response (Yes or No) regardless of coverage.

Are you covered by:	**Other Medical:** Y or N	**Other Dental:** Y or N	**Medicare:** Y or N
Is your spouse covered by:	**Other Medical:** Y or N	**Other Dental:** Y or N	**Medicare:** Y or N
Are your dependents covered by:	**Other Medical:** Y or N	**Other Dental:** Y or N	**Medicare:** Y or N

NOTE: Claims processing may be delayed pending your response.

NOTE: If at any point, after the date of this letter, you and/or your dependents coverage situation changes please contact our office @ 561-969-6663, so that we can obtain the proper information needed to properly coordinate benefits with the other carrier.

***** IMPORTANT *****

When Sending this form back please also include a copy of any other insurance carrier's ID card front and back (if any). Without this card we may be unable to verify eligibility and therefore be unable to coordinate benefits with your other carrier.

Policy Holder Signature: _____ **Date:** _____