CoreSource
A Trustmark Company

Coordination of Benefits (COB) Form – Group No. 2274

Employee Last Name:	Employee First Name:	Member ID#:

SECTION 1: Other than the St. Jude medical plan, does your spouse/partner or child(ren) have coverage with other group medical plans such as HMO, Medicare, Blue Cross/Blue Shield or other employer or state plans? Check either Yes or No:

Yes ☐ **No** ☐

If "no" complete Section 3 and fax the signed form to Sandy Hayden, CoreSource, at 1-410-931-8970 or scan and email it to CoreSourceStJudeServiceTeam@coresource.com. If "yes" complete section 2 and 3 before submitting to CoreSource.

SECTION 2: Provide the following information for your spouse/partner and/or EACH child indicating any other medical plan(s) your spouse/partner and/or EACH child are covered under, in addition to the St. Jude Medical Plan.

	Spouse/Partner	Child 1	Child 2*
Insured's Name (First and Last)			
Insurance Company			
Insurance Company Telephone Number			
Policy Number			
Effective Date of Policy			
Who is covered by the other health plan? (Please include name and relationship)			
Identify if any court mandated coverage, such as a divorce decree, exists for any of your children having coverage through another medical plan.			
*If additional space is needed, please use additional forms or attach a second p			

SECTION 3: I certify that the statements and answers contained on this questionnaire are true and complete to the best of my knowledge. I recognize that I am responsible for refunding my Employer's Plan for any overpayments which are made as a result of any incomplete or inaccurate answers. In the event that you have questions regarding this questionnaire, I have included my day time telephone number below.

Employee Signature:	Daytime phone number:	Date: