

# Medicare Supplemental COB Declaration Form

## Member Information

Full Name

Date of Birth

Medicare ID

Phone Number

Address

## Other Insurance Information

Do you have any other health insurance?

If yes, Insurance Company Name

Policy or Group Number

Effective Date

## Coordination of Benefits

Which insurance is your primary coverage?

Comments

## Certification

I certify that the above information is true and correct to the best of my knowledge.

Signature

Date