Montana Association of Counties
Health Care Trust
2717 SKYWAY DRIVE, SUITE D, HELENA, MT 59602
(406) 443-8102 (toll free) 866-669-6428 Fax (406) 443-8103
www.mtcounties.org/hct

Re: Annual Information Request

Dear MACo Health Care Trust Member,

On the reverse side of this letter you will find a short form requesting information related to other insurance coverage for yourself and your family. We must request this information every year in order to keep our records current and to prevent delays in processing your claims. We recognize that it is an inconvenience for you to have to complete this questionnaire on a yearly basis. However, it is the only resource we have available to obtain and maintain this critical claims processing information. Your cooperation will be greatly appreciated. **A response is required prior to any future claims processing, even if the response is that there is no other insurance coverage.**

Please take a moment now to complete the form and return it. Alternatively you may fax the form on the back of this page to us Toll Free at 866-201-0522, you may email a response to *cobinfo@askallegiance.com* or you may access our web site at www.askallegiance.com to submit the questionnaire online. If you go to the website, click on "*I am a Member*" under **Health Benefits**. Choose *Allegiance Benefit Plan Management* and click on *Forms*. Then choose *C.O.B. Questionnaire* under **Health Claim Forms**.

Your rapid response will be greatly appreciated and will enable us to process your claims in a timely fashion. Failure to respond may delay claims processing at the time the claims are received; therefore we strongly encourage you to take the time to respond now. Thank you for your assistance. If you have any questions regarding this request, please contact our Customer Service Representatives at 1-888-883-3233.

Sincerely,

Allegiance Benefit Plan Management, Inc
On behalf of MACo Health Care Trust

ANNUAL COORDINATION OF BENEFITS (COB) QUESTIONNAIRE

In order to insure proper processing of your health claims, please complete and return this form.

Allegiance Benefit Plan Management, Inc.
PO Box 3018
Missoula, MT 59806

This form may be returned by fax toll-free 1-866-201-0522 or emailed to **cobinfo@askallegiance.com.** If you choose to email your response, please include your full name and group number.

Member Name:_____
Group Number: _____ Group Name: MACoHCT: _____
Do you have any health coverage (includes Medicare coverage) other than that provided by the Group Name listed above? Y N
If yes, Name of other insurance: _____

Telephone Number: _____ Effective Date of Coverage:_____

Primary Insured's Name/Relation: _____Date of birth:_____

Group Number:_____ Policy #_____

Type of coverage (please circle) Medical Dental Vision RxCard Disability Supplemental

Individual Group Life COBRA Retiree

If Medicare, is it for End Stage Renal Disease? Yes_____No_____

If ESRD, when did dialysis treatments begin? _____

If Medicare, indicate type of coverage elected and beginning date for each –

Part A_____ Part B_____ Part D_____

Does your spouse or covered dependents have other health coverage? Y N
If yes, Name of other insurance: _____

Telephone Number: _____Effective Date of Coverage: _____

Primary Insured's Name/Relation: _____Date of birth:_____

Group number: _____ Policy # _____

Type of coverage (please circle) Medical Dental Vision RxCard Disability Supplemental

Individual Group Life COBRA Retiree

Names of dependents covered by other plan: _____

If Medicare is it for End Stage Renal Disease? Yes_____No_____

If ESRD, when did dialysis treatments begin? _____

If Medicare, indicate type of coverage elected and beginning date for each –

Part A_____ Part B_____ Part D_____

If this coverage is the result of a court order, please attach a copy of the applicable order

May we call you if additional information is required? Y N Area code and phone # _____

Thank you for responding to this questionnaire. Please do not hesitate to contact us if you have any questions. Our Customer Service Team may be reached at 1-888-883-3233.

_____ _____
Signature Date