Dear Participant:

Your contract for behavioral health care coverage through *Carelon Behavioral Health, Inc.* contains a Coordination of Benefits (COB) provision that requires *Carelon Behavioral Health, Inc.* to investigate any duplicate coverage or benefits to which you may be entitled. Please complete the questionnaire and return it to *Carelon Behavioral Health, Inc.,* Attn: COB Department. If you have any questions pertaining to this questionnaire, please contact Member Services at the number listed on your benefits card.

If you are unsatisfied with our decision to request completion of the questionnaire to process your claim(s) you have the right to request a grievance. A grievance must be requested within 90 calendar days of your receipt of this notice. Please identify the issue and provide any comments or supporting documentation that you wish to be considered in the resolution of your grievance. To contact *Carelon Behavioral Health, Inc.* to file a grievance, call your Member Services department at the number listed on your benefits card or in writing to:

Carelon Behavioral Health, Inc.
Attn: Complaints and Grievance Coordinator
PO Box 1851
Hicksville, NY 11802

Thank you for providing the requested information so that we may continue to process your claim(s) properly.

Sincerely,

Carelon Behavioral Health, Inc.
COB Processing Unit
PO Box 1850
Hicksville, NY 11802-1850

Carelon Behavioral Health, Inc. COB Questionnaire
SAG-AFTRA Health Plan

SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Subscriber Name: _____ Subscriber ID#: _____
Employment Information (Please check the appropriate boxes)
Actively at Work: ☐ Yes ☐ No
Total number of employees at company is: ☐ 1-19 ☐ 20-99 ☐ 100+
Retired: ☐ Yes ☐ No Date of Retirement: _____/_____/_____
Spouse's ID#: _____
Spouse's Name: _____ Spouse's Date of Birth: __ __/_____/_____

COVERAGE INFORMATION

- Please Note: If you, your spouse, or dependent(s) have other mental health/substance use coverage currently or within the last 24 months, please complete the appropriate section(s) below. If this does not apply, please sign and date the form below and return to Carelon Behavioral Health, Inc.

PART A

1. Current other mental health/substance use coverage
   Carrier Name: _____
   Subscriber's Name: _____ Subscriber's ID#: _____
   Policy Effective Dates: Start _____/_____/_____ End _____/_____/_____
   Covered Dependents: _____
2. Have you or any member of your family (covered on this plan), had other mental health and substance use coverage within the last 24 months? ☐ Yes ☐ No
   Carrier Name: _____
   Member's Name: _____ Member's ID#: _____
   Policy Effective Dates: Start _____/_____/_____ End _____/_____/_____
   Covered Dependents: _____

PART B: Complete if divorced, legally separated, or a single parent and you have dependent children covered under this plan.

1. Does the other biological parent of your dependent child(ren) provide mental health/substance use coverage? ☐ Yes ☐ No
   If yes, please provide the following information:
   Name of other mental health/substance use plan: _____
   Subscriber's ID#: _____
2. Are you divorced or legally separated? ☐ Yes ☐ No
   Date of divorce/separation: _____/_____/_____
   Are you a single parent? ☐ Yes ☐ No

Please provide a copy of the section of the court decree pertaining to health coverage.

PART C: Complete this section if you, your spouse and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each member of your family**.**

1. Name of Member eligible for Medicare: _____
   Effective Dates of Medicare: Part A: _____/_____/_____ Part B: _____/_____/_____
2. Reason for Medicare coverage, please check one:
   ☐ Age 65 or older ☐ Retirement ☐ Disability
   ☐ End Stage Renal Disease (ESRD) Date Dialysis Treatment Began: _____/_____/_____

Signature: _____ Daytime Telephone #: _____ Date: ____/____/_____