



MARICOPA
COMMUNITY
COLLEGES®

ZENITH
ADMINISTRATORS

2001 W CAMELBACK RD., STE B350
PHOENIX, AZ 85015

PHONE: 866-289-6245 FAX: 602-248-8301

COORDINATION OF BENEFITS

Dear Maricopa Community Colleges Employee,

Please complete the following information and return to Zenith Administrators to prevent any delays in claims payments. The following information is being requested to determine if coordination of benefits applies to your medical coverage with Zenith Administrators. This information will be requested from all members on an annual basis. **If you do have other insurance please submit a copy of the primary Explanation of Benefits with each claim submission. (If you are waiving MCCCDC's insurance please disregard this notice.)**

EMPLOYEE NAME: _____ EMPLOYEE ID#: _____

POLICY NAME: MCD001

IS ANY FAMILY MEMBER COVERED BY ANY OTHER **GROUP** INSURANCE PLAN (INCLUDING MEDICARE)? YES NO
IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURANCE: _____

SUBSCRIBER NAME & BIRTHDATE _____

SUBSCRIBER SOCIAL SECURITY NUMBER: _____-_____-_____

GROUP NUMBER / EFFECTIVE DATE _____ / ____/____

FAMILY MEMBER(S) COVERED BY PLAN:

INSURED DEPENDENT: _____ SOCIAL SECURITY #: _____

INSURED DEPENDENT: _____ SOCIAL SECURITY #: _____

INSURED DEPENDENT: _____ SOCIAL SECURITY #: _____

INSURED DEPENDENT: _____ SOCIAL SECURITY #: _____

TYPE OF COVERAGE (CHECK ALL THAT APPLY)

MEDICAL DENTAL PRESCRIPTION VISION

IF DIVORCED OR LEGALLY SEPARATED, DOES THE DECREE SPECIFY WHICH PARENT IS RESPONSIBLE FOR PROVIDING HEALTH, PRESCRIPTION, AND/OR DENTAL COVERAGE FOR THE CHILD (REN)?

YES NO

NAME OF PARENT WITH CUSTODY _____

I CERTIFY THE ABOVE IS TRUE, CORRECT AND COMPLETE

SIGNATURE OF EMPLOYEE

_____/____/_____
DATE

IF THE ABOVE INFORMATION IS NOT COMPLETED IN FULL, OR AS REQUESTED PERIODICALLY, CLAIMS MAY BE DELAYED OR DENIED UNTIL INFORMATION REQUESTED IS PROVIDED TO ZENITH ADMINISTRATORS.

Thank You,
ZENITH ADMINISTRATORS, INC.