NORTHERN BUCKEYE EDUCATION COUNCIL
COORDINATION OF MEDICAL BENEFITS FORM

For NBEC Administrative Use Only

PLAN #	LOCATION	STATUS		EFFECTIVE DATE	VERIFIED BY
AP-1	NSA	A			

In order to update our records, please provide the following information:

PLAN NAME **Northern Buckeye Education Council**	CLIENT # **817**	SCHOOL **NW STATE COMMUNITY COLLEGE**	
EMPLOYEE NAME FIRST M.I. LAST		EMPLOYEE SOCIAL SECURITY #	EMPLOYEE DATE OF BIRTH

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER GROUP PLAN? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE THE FOLLOWING FOR THE INSURED PERSON

NAME OF INSURED PERSON	GENDER	BIRTHDATE	SOCIAL SECURITY NUMBER

IS THE INSURED PERSON RETIRED? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE THE FOLLOWING EMPLOYER INFORMATION

EMPLOYER NAME	EMPLOYER STREET ADDRESS	EMPLOYER CITY	EMPLOYER STATE	EMPLOYER ZIP

PLEASE LIST DEPENDENTS COVERED BY ANY OTHER GROUP PLAN

DEPENDENT NAME #1	DEPENDENT NAME #2	DEPENDENT NAME #3	DEPENDENT NAME #4	DEPENDENT NAME #5

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ANY OTHER INSURANCE COMPANY/ORGANIZATION PROVIDING BENEFITS

NAME OF INSURANCE COMPANY	STREET ADDRESS	CITY ST ZIP	PHONE
POLICY PLAN NUMBER	EFFECTIVE DATE	TYPE OF COVERAGE ☐ MEDICAL ☐ PRESCRIPTION DRUG	
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POLICY PLAN NUMBER	EFFECTIVE DATE	TYPE OF COVERAGE ☐ MEDICAL ☐ PRESCRIPTION DRUG	

I agree to immediately report any changes to any of the information included on this form.

_____
EMPLOYEE SIGNATURE DATE

Please return this completed form to your school's Human Resources office.