UNDERSTANDING CO-ORDINATION OF BENEFITS

If you, your spouse, or your dependents are also covered by another plan (such as through your spouse's employer), you may need to submit your family's health and dental claims to both plans. This process is called Co-ordination of Benefits (COB).

If the claim is for you (you are the patient)

Submit the claim to your health or dental plan first, by completing the claim form. Keep a copy of the claim form. Once the Plan Administrator has assessed and/or paid the claim, you will receive a written explanation. Then submit the claim (with the explanation and copy of the original claim form) to your spouse's benefit plan to be reimbursed for the remaining portion.

If the claim is for your spouse (your spouse is the patient)

Submit the claim to your spouse's health plan first. Complete the claim form for that plan and keep a copy of the claim form. Once your spouse's plan has assessed and/or paid the claim, submit the claim to the Plan Administrator for them to assess the claim. Send the Plan Administrator the explanation that the other plan sent to your spouse, along with the copy of the claim form that you kept. You will need to attach and sign a completed claim form.

If the claim is for your dependent child

The parent whose birth date (month and day) occurs first in the year, submits the claim to their plan first. The other parent will then submit the remaining portion of the claim to their plan (see instructions above).

Co-ordination of Benefits allows you to receive reimbursement of your claim from both benefit plans up to the full cost of your claim. It is not intended that you receive reimbursements greater than the actual health/dental expenses incurred. Therefore, any coverage you have under other "plans" will be taken into account in determining the amount of benefit payable under this Plan, and the benefits under this Plan will be co-ordinated with the benefits of the other plans.

Important Notes

If your current spouse has an alternate coverage, please select the 'Spouse's Policy' Co-ordination of Benefit Type.

If your dependent child/children have an alternate coverage through a parent not covered under your policy, please select the 'Other Parent Policy' Co-ordination of Benefit Type, and provide the other parent's Date of Birth (DOB).

The Board of Trustees/Employer has the power to disentitle any person to past, present, or future benefits and to take any further action deemed appropriate, including denying membership in the Plan to any person where the member or persons claiming through the member are found by the Trustees/Employer to be abusing the plan or making false or improper claims under the Plan.

Plan Administrator:

Manion, Wilkins and Associates Ltd
500-21 Four Seasons Place
Etobicoke, Ontario M9B 0A5

Tel: (416) 234-3511 or toll-free 1 866 532 8999 email: askus@mymanion.com

CO-ORDINATION OF BENEFITS FORM

Profile

Help us easily identify your information by completing the information required below.

Plan or employer name

Certificate number

Member name

Member date of birth

Other Coverage

Do you or any other member of your family have coverage through another medical or dental provider?

☐ No ☐ Yes

Indicate who has alternate coverage: ☐ Member ☐ Spouse ☐ Chid

Are those you indicated as having alternate coverage through: ☐ Spouse's Policy ☐ Other Parent's Policy

Other insurance company name

Other insurance company policy number

Other Parent's Date of Birth

Benefits covered by other insurance (check that coverages apply):

☐ Extended Health ☐ Dental ☐ Vision ☐ Prescription Drugs

Effective date of coverage through other insurance company

End date of coverage through other insurance company

Agreement of Understanding

I agree that, should the information provided change in the future it is my responsibility to advise the Plan Administrator, in writing, by completing and filing a revised Co-ordination of Benefits Form.

I agree that, should the information provided change in the future it is my responsibility to advise the Plan Administrator. I hereby certify that the above statements are true, accurate, and complete to the best of my knowledge and belief. I understand that Manion, Wilkins & Associates Ltd (Manion) will use the information provided by me on this form to process my claims. I understand, acknowledge, and agree that my personal information will be used in accordance with Manion's privacy policy found at https://www.manionwilkins.com/privacy/. I hereby authorize Manion to release the personal information contained on this form to qualified third parties or insurance companies for the purpose of investigating or evaluating my claims or co-ordinating my benefits, to the extend required for such purposes. A photocopy of this form shall be as valid as the original.

Signature of member

Date