

Coordination of Benefits Form for Medical Insurance Request for Insurance Coverage Information

This form is a request for coordination document we must have to update your insurance records and provide proper coverage. **This form is ONLY for use by FOP members hired after Jan. 1, 2021.**

All other employees should use version NCC-2025. Completed forms should be submitted to the Office of Human Resources:

vicki.workinger@newcastlede.gov

If your spouse (SP) is covered under a NCC medical insurance plan, please complete this form. Failure to timely submit this form could result in your denial of medical/prescription claims.

Section A. – NCC Employee Information			
Employee ID	First and Last Name	Telephone Number	Email Address
Section B. – Insurance coverage information excluding Medicare. (Check all that apply)			
My NCC coverage level is: <input type="checkbox"/> Individual <input type="checkbox"/> Employee with Child/Children <input type="checkbox"/> Employee with Spouse <input type="checkbox"/> Family <input type="checkbox"/> Yes <input type="checkbox"/> No - My Spouse has access to insurance coverage other than through NCC. <input type="checkbox"/> Yes <input type="checkbox"/> No - My Spouse can purchase coverage through an employer for less than 50% of the premium cost of the plan per month.			
Section C. – Current Spouse’s Insurance Company through THEIR Employer			
Policy Holder	Date of Birth	Contract Number	Coverage Effective Date
<u>Name of Insurance Company (check one)</u> <input type="checkbox"/> Aetna <input type="checkbox"/> BlueCross/Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> United Healthcare <input type="checkbox"/> Tricare <input type="checkbox"/> Other _____		<u>Coverage provided through</u> <input type="checkbox"/> Current Employer <input type="checkbox"/> Former Employer <input type="checkbox"/> Other _____	
		<u>Type of Coverage</u> <input type="checkbox"/> Medical with prescriptions <input type="checkbox"/> Medical without prescriptions	
Section D. – Acknowledgement/Employee Certification			
<ul style="list-style-type: none"> I understand that the coordination of benefits policy applies to spouses who work full-time and have eligibility for medical coverage associated with that employment. I understand that this information will be shared with NCC medical plan administrators. I understand that coverage provided by the employer of my spouse will be primary over any coverage provided through NCC. I understand that if my spouse can obtain 2025 insurance coverage for less than 50% of the premium cost of the plan per month, they are required to enroll in such plan for the purpose of assuring claims are properly processed in accordance with primary versus secondary insurer rules. My signature is certification that the information provided is correct as of the date it is signed. 			
Signature: _____		Date: _____	
Notice to parties completing this form: To ensure medical benefits are coordinated properly between employers, NCC will verify the accuracy of this information through audits, contacting you, and your spouse’s/DP employer. It is fraudulent to complete this form with information that is false or to omit facts. Providing inaccurate information may result in disciplinary action.			