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

Completed forms should be submitted to the Office of Human Resources:
hrbenefits@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: □ Individual □ Employee with Child/Children □ Employee with Spouse/DP □ Family

□ Yes □ No: My Spouse/DP has access to insurance coverage other than through NCC.

□ Yes □ No My Spouse/DP can purchase coverage through an employer for under $122.00 per month

□ Yes □ No - My Spouse's Employer pays more than 50% of the monthly premium for the spouse **(FOP hired after January 1, 2021, only)**

Section C. – Current Spouse or DP's Insurance Company **through THEIR Employer**

Policy Holder	Date of Birth	Contract Number	Coverage Effective Date

Name of Insurance Company (check one)	Coverage provided through	Type of Coverage
□ Aetna □ BlueCross/Blue Shield	□ Current Employer	□ Medical with prescriptions
□ Cigna □ United Healthcare	□ Former Employer	□ Medical without
□ Tricare □ Other _____	□ Other _____	prescriptions

Section D. – Acknowledgement/Employee Certification

- I understand that the coordination of benefits policy applies to spouses or domestic partners 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/DP will be primary over any coverage provided through NCC.
- I understand that if my spouse/DP can obtain 2027 insurance coverage for less than $122.00 per month or the Employer will pay at least 50% of the monthly premium for the spouse, 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 submit this form with information that is false or to omit facts. Providing inaccurate information may result in disciplinary action.