



**SPOUSE COORDINATION OF BENEFITS
GROUP HEALTH INSURANCE ENROLLMENT
CONFIRMATION**

FORM 4

SPOUSE'S EMPLOYER INFORMATION

[please print clearly]

Employer Name:	Contact:		
Address:	Email:		
City:	State:	ZIP:	Phone:

<input type="checkbox"/> YES, enrolled. Please provide insurance information.	<input type="checkbox"/> NO, did not enroll. The Plan will send you new forms for completion.	Reason you did not enroll: <input type="checkbox"/> No longer employed <input type="checkbox"/> No longer eligible for employer insurance <input type="checkbox"/> New employer <input type="checkbox"/> Other:
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INSURANCE INFORMATION

[please print clearly]

Group Health Plan Name:			
Address:			
City:	State:	ZIP:	Phone:
Medical/Hospital effective date:	Group Number	Policy Number	Cancellation date (if applicable)
Prescription Coverage effective date:			

If a spouse or same-sex domestic partner ("DP") enrolls in his/her employer's health insurance, and child dependents can be enrolled, you **MUST ENROLL** the child(ren) unless there is a premium for the children, or the spouse or DP's birth date is later in the year than the Participant's birth date. Children enrolled: No Yes

Children covered under this policy	Birth Date	Policy Number	Effective Date	Termination Date

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT, and I understand that, to ensure that benefits are coordinated properly, MPIHP will verify the accuracy of information by conducting audits, contacting me, my spouse's employer, and/or insurance plan. It is fraudulent to knowingly fill out this form with any information that is false.

Participant's Signature [required – please print]	Social Security Number	Date [required]	(Area Code) Ph. No.
Spouse's Signature [required – please print]	Social Security Number	Date [required]	(Area Code) Ph. No.

INCOMPLETE FORMS AND/OR FORMS MISSING PARTICIPANT'S AND SPOUSE'S SIGNATURES WILL BE RETURNED IF ANY INFORMATION ON THIS FORM CHANGES, A NEW FORM MUST BE SUBMITTED WITHIN 30 DAYS

Questions call: 818 or 310.769.0007 Ext 263 / Outside So. Calif: 1.888.369.2007 Ext 263,
or E-mail: eligibility@mpihp.org