Coordination of Benefits Form

Please complete and return this form within 14 days to prevent denial of any pending claims.

Your dental plan contains a Coordination of Benefits (COB) provision. By coordinating benefits with your other carrier, we may be able to reduce your out-of-pocket expenses for covered services.

SECTION 1 - DELTA DENTAL OF KANSAS SUBSCRIBER INFORMATION

Primary Subscriber Name: _____ Member Number: _____
(Found on your Member ID card) (Found on your Member ID card)

Are you, your spouse or any of your dependents covered by another dental plan?

☐ Yes (If yes, complete this form) ☐ No (If no, sign and return)

SECTION 2 - OTHER DENTAL INSURANCE INFORMATION

Policyholder Information

Policyholder Name: _____ Policyholder Member ID: _____

Policyholder Date of Birth: _____ Employer: _____
(If applicable)

Other Dental Insurance Carrier Information

Dental Insurance Carrier Name: _____ Group #: _____

Address:_____ City: _____ State: _____ ZIP: _____

Who is covered under this dental plan? (please include yourself if applicable)

Name (First and Last)	Coverage Effective Date	Coverage Term Date

Name (First and Last)	Coverage Effective Date	Coverage Term Date

If this coverage is provided by a Department of Defense health benefit program, which statement listed below is most applicable?

☐ Full-Time Active Duty ☐ Active Reserves ☐ Military Retiree ☐ Other: _____

SECTION 3 - SPECIAL SITUATIONS

Complete this section ONLY if parents are divorced, legally separated or there is a court order.

Is there a court order that determines responsibility for health/dental care coverage or custody?

☐ Yes (If yes, attach a copy of the sections that apply to health/dental care responsibility and/or custody arrangements) ☐ No

Child Name	Person with Custody (more than 50%) Name and Relationship	Person Responsible for Health/Dental Care Name and Relationship	Name of Other Insurance Carrier

Delta Dental of Kansas Primary Subscriber Signature: _____ Date: _____

Return to Delta Dental of Kansas:
email: COB@deltadentalks.com | mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3392

800.234.3375 | DeltaDentalKS.com

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