Coordination of Benefits (COB) Form Instructions

If you, your spouse, or dependent(s) carry other insurance, please complete this form and return to EMI Health. Having up-to-date COB information helps maintain the efficiency and cost-effectiveness of your EMI Health insurance plan.

Please complete and sign the COB Form and click on the "Submit" button at the bottom. Or return any of the following ways:

Email: enrollment@emihealth.com

Mail to: EMI Health
1501 S. Commerce Drive
Murray, UT 84107
Attn: Enrollment

Fax to: (801) 269-9734

If you have any questions,
please call our customer service at (800) 662-5851, 6:00am-6:00pm MST, Monday-Friday.

Coordination of Benefits (COB)

Policy Holder Name

Member ID Number

What type of coverage is the other policy?

☐ Medicare Part A ☐ Medicare Part B ☐ Medical ☐ Dental ☐ Vision

What is the other coverage classification?

☐ Single ☐ Couple ☐ Family

List all dependent(s) covered by other carrier

Name of Insured

Insured's Date of Birth

Insured's Policy Number

Name of Other Insurance Company

Effective Date

Insurance Company Phone Number

If parents are divorced or legally separated, the following information is needed to determine which coverage will process claims as primary for the dependent children.

Please enclose a copy of the divorce decree

Names of Child/Children

Name of person with custody

Relationship to child

Name of person with financial responsibility for the health coverage according to the divorce decree?

The above information is accurate and complete to the best of my knowledge.

Please sign:

Signature

Date

Submit