Custom Design Benefits

Custom Design Benefits (CDB) is committed to quickly and efficiently handling your healthcare claims. In order to ensure this occurs, we need to verify annually if you or any of your dependents (if applicable) have other insurance coverage. CDB coordinates insurance benefits with other carriers and this information is used solely for that purpose.

Employee Name: _____ **Employer:** _____

Are you or any of your dependents covered under another group's insurance plan? ◯ Yes ◯ No

If Yes, please complete the section below. If No, skip this section and sign and date the bottom of this form.

Name of Primary Insured for other Carrier: _____

Date of Birth: _____

Other Insurance Carrier Name, Address and Phone Number:

_____

Insurance Policy Number: _____
Effective Date of the Policy: _____

Type of Plan: ☐ Medical ☐ Dental ☐ Vision
Type of Coverage: ◯ Family ◯ Insured plus Dependent(s) ◯ Individual Only
Is this plan: ◯ Retiree ◯ Active
Is this policy required by court order to be primary? ◯ Yes ◯ No
If Yes, please provide a copy of the court order.

If there is family coverage, please list family members covered under the plan:

_____

_____

Are any members listed also covered under Medicare? ◯ Yes ◯ No
Name: _____ **Medicare ID Number:** _____
Medicare A: ◯ Yes ◯ No **Effective Date:** _____
Medicare B: ◯ Yes ◯ No **Effective Date:** _____
If your Medicare Eligibility is due to a disability, please describe your condition:

_____

Are any members listed also covered under Medicaid? ◯ Yes ◯ No
Name(s): _____
Medicaid ID Number: _____
Effective Date: _____

Signature: _____ Date: _____

Once completed and signed, please return via email to Eligibility@customdesignbenefits.com, fax to (513) 598-2913, or mail to Custom Design Benefits, 5589 Cheviot Road, Cincinnati, OH 45247.

If you have any questions, please contact us at (800) 598-2929.

Sincerely,
Eligibility Department