



AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
 Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com

For AMO Official Use Only

Received Date: _____

Received By: _____

COORDINATION OF BENEFITS FOR DEPENDENT SPOUSE AND DEPENDENT CHILDREN

IF YOU ARE REQUESTING COVERAGE FOR SPOUSE OR OTHER DEPENDENTS, THE PLAN REQUIRES A COPY OF MARRIAGE AND BIRTH CERTIFICATES IF NOT PREVIOUSLY SUBMITTED.

PARTICIPANT INFORMATION

| | | | |
|--|---|---|---|
| Participant's Name: | | SSN: XXX-XX- | DOB: |
| Street Address: | | | |
| City: | | State: | ZIP Code: |
| Home Telephone No.: | | Cell Phone No.: | |
| Email Address: | | | |
| Marital Status: | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced Date of Divorce: _____ | <input type="checkbox"/> Legally Separated Date of Separation: _____ |
| COMPLETE COPY OF APPLICABLE LEGAL DOCUMENTS REQUIRED TO BE SUBMITTED IF NOT PREVIOUSLY SUBMITTED. | | | |

DEPENDENT INFORMATION

List below name of eligible dependents

| Dependent's Name | Social Security Number | Check Relationship to Participant | | | | Date of Birth | | | Is dependent covered under another health plan? | |
|------------------|------------------------|-----------------------------------|---------------|------------|-----------------------------|---------------|-----|------|---|----|
| | | Spouse | Natural Child | Step Child | Legal Guardianship/ Custody | Month | Day | Year | Yes | No |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

In order for a dependent to be considered eligible for medical benefits under the AMO Medical Plan, **the dependent must meet the requirements** of An Eligible Dependent in accordance with the Rules and Regulations of the AMO Medical Plan. Please see the Medical Plan Summary Plan Description for more information. **You are required to notify the plan office immediately** if any change in dependent status occurs. Failure to do so may result in loss of eligibility for medical benefits and may require reimbursement of any benefits for medical services on dependent's behalf.

ELIGIBILITY

Eligibility and Documentation Requirements for a Dependent Spouse:

- The spouse of a Participant who is eligible for medical benefits provided that any benefit payable with respect to such spouse shall cease upon the date of divorce or legal separation from the Participant.
- **If the dependent spouse is employed full time**, the Rules and Regulations of the AMO Medical Plan require that the Plan consider group medical coverage offered through a dependent spouse's full time employment first and the AMO Medical Plan will be secondary. For the purposes of determining full time employment status, 30 hours or more per week will be considered full time. Note: Should a change take place regarding employment status, you must notify the Plan office.
- **If group medical coverage is rejected by a dependent spouse**, the AMO Medical Plan will only pay claims at twenty percent of the otherwise eligible benefit.
- A Coordination of Benefits form must be completed and signed by the participant.

DEPENDENT SPOUSE INFORMATION

| | | | |
|--|--|--|---|
| 1. Is the dependent spouse employed full time? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time (30 hours or more per week) |
| If yes, name of employer: | | Employer Phone Number: | |
| Address of Employer: | | | |
| City: | | State: | ZIP Code: |
| 2. Is dependent spouse eligible for Group Coverage through employment? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, Carrier Name: | | Policy Number: | |
| Telephone Number: | | Effective Date of Coverage: | |
| 3. What type of Insurance is offered? | <input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Optical <input type="checkbox"/> Dental | | |
| 4. Have any of these been rejected or waived? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, date of rejection: | Medical _____ Prescription _____ Optical _____ Dental _____ |
| 5. Is dependent spouse eligible for coverage during the next enrollment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of next enrollment: | |

DEPENDENT CHILDREN INFORMATION

| | | |
|---|--|--|
| 1. Are there any legal documents assigning responsibility to provide medical coverage for any dependent children, stepchildren, or children under legal guardianship custody? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, insured's name: | | Name of Carrier: |
| Carrier's Phone Number: | | Effective Date of Coverage: |
| 2. Type of coverage: | <input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Optical <input type="checkbox"/> Dental | |

"Group cover" means any Plan providing medical, prescription, optical, or dental care services. Examples of Plan considered under coordination of benefits are:

- Group, blanket or franchise insurance coverage, or no-fault motor vehicle insurance.
- Group health plans.
- Any coverage under labor management trustee plans, union welfare, employer organization plans, or employee benefit organization plans.
- Any coverage under governmental programs including the Federal Medicare Program, CHAMPUS, or Tricare.

CERTIFICATION OF INFORMATION

I hereby certify that the information contained herein is true. I agree to notify the Plan of any changes that occur which may change my dependent's coverage. I further understand that if I make false statements to American Maritime Officers Medical Plan, I may jeopardize my Medical Plan benefits and coverage and will be required to return any benefits paid for medical services

SIGNATURE

| | |
|------------------------|-------|
| Participant Signature: | Date: |
|------------------------|-------|