



SELF FUNDING ADMINISTRATORS CORPORATION

339 BUSCHS FRONTAGE ROAD

POST OFFICE BOX 6596

ANNAPOLIS, MARYLAND 21401

Dear Employee,

Your Group Medical Plan contains a Coordination of Benefits clause. In order to determine the correct order of benefit payments, we need you to complete the following information for your spouse and/or dependents and return to SFA at the address listed above, or via fax at 410-349-9724.

Employee's Name _____ SS # or ID # _____

Employer _____

Are your spouse and/or dependents covered by other dental or medical insurance? Yes No

If no, stop here, sign, date below and return to SFA. Thank you for your time.

The name and address of your spouse/dependents' employer _____

Name and date of birth of spouse _____

Name of other medical plan: _____

Policy number _____ Phone number of claims office _____

Effective date _____

Please list all members covered under other medical plan _____

Name of other dental plan: _____

Policy number _____ Phone number of claims office _____

Please list all members covered under other dental plan _____

Signature _____ **Date** _____

Your plan requires that we update this information at least once a year. Failure to fully complete this information could delay payment of your claims or make them ineligible for coverage. If you have any questions, please do not hesitate to contact Customer Service at 800-424-8611.

Thank you,

Self Funding Administrators

