WMI® Mutual Insurance™ Company

P.O. Box 572450, Salt Lake City, Utah 84157-2450
Telephone: 801-263-8000 Toll Free: 800-748-5340
Claims Fax: 801-263-1189

COORDINATION OF BENEFITS INFORMATION

It is necessary for WMI Mutual Insurance Company ("WMI") to determine whether you or your dependent(s) have duplicate coverage in order to process claims accurately and timely. Please provide our office with the following information:

Name of Employee _____ Employee SSN _____

Employee's Address _____ Phone No. _____
Street City State Zip

Name of Employee's Employer _____ Group Policy No. _____

Name of Spouse's Employer (if not employed, write "none") _____

In addition to your coverage with WMI, are you or any of your dependent(s) currently covered under any other health insurance policy (including a health maintenance organization or governmental plan)?
_____ Yes _____ No If yes, please specify below.

Name of individual with Medical, Dental, or Vision coverage in addition to the coverage with WMI	Other insurance company's name, address and phone number	Policy no. and member ID# of other insurance	Effective Date of other insurance	Type of other insurance coverage	If other Medical coverage, does it include Rx coverage
				☐ Medical ☐ Dental ☐ Vision	☐ Yes ☐ No
				☐ Medical ☐ Dental ☐ Vision	☐ Yes ☐ No
				☐ Medical ☐ Dental ☐ Vision	☐ Yes ☐ No
				☐ Medical ☐ Dental ☐ Vision	☐ Yes ☐ No
				☐ Medical ☐ Dental ☐ Vision	☐ Yes ☐ No
				☐ Medical ☐ Dental ☐ Vision	☐ Yes ☐ No

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, government agency, insurance company, the Medical Information Bureau, or other organization or person that has any records or knowledge of myself and my dependents for whom coverage is requested to disclose to WMI any such information. I expressly waive on behalf of myself, my spouse and such dependents any legal action for such disclosure. A photographic copy of this authorization shall be as valid as the original.

_____ _____
Signature of Employee **Date**

The submission of fraudulent claims or false or misleading information may subject the person who provides the fraudulent information to fines and/or imprisonment, pursuant to state and federal laws.