

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 insurance 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: Medical/Dental/ Vision

I authorize any physician, medical practitioner, hospital, clinic, any other provider of health care, or insurance company to disclose to WMI or its representatives all information and records of myself and my dependents relating to diagnosis, treatment, medical history, physical or mental condition, and evaluation thereof for which coverage by WMI is sought. I expressly waive on behalf of myself, my spouse and such dependents any legal action for such disclosure. A copy of this authorization shall have the same effect 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.