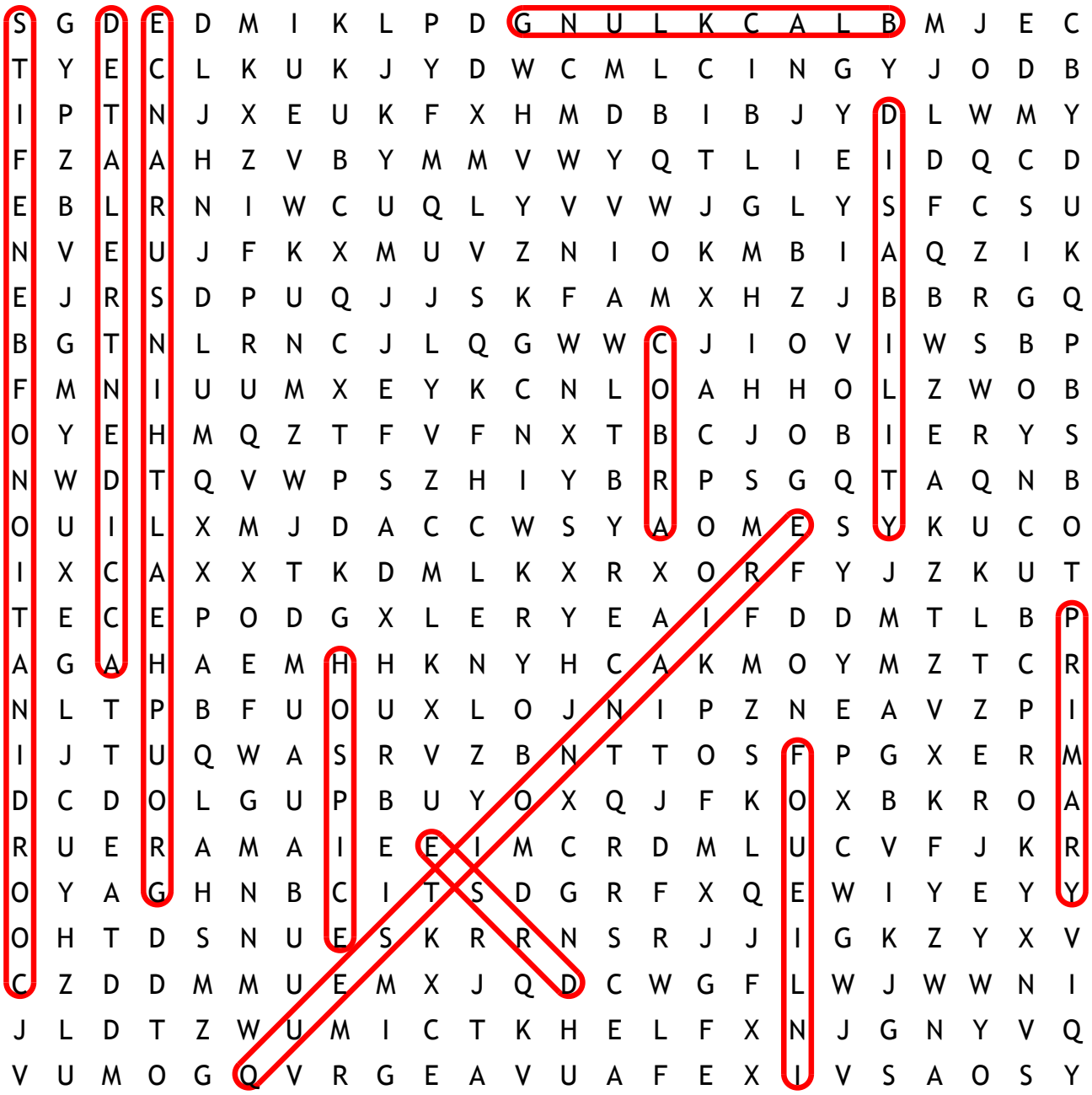
Name: _____ Date: _____

Medicare Compliance COB



COORDINATION OF BENEFITS

QUESTIONNAIRE

IN LIEU OF

COBRA

GROUP HEALTH INSURANCE

DISABILITY

PRIMARY

ESRD

ACCIDENT RELATED

BLACK LUNG

HOSPICE