Coordination of Benefits Request Form

The Chevron Phillips Chemical Company LP plans require that all participants complete a Coordination of Benefits Request Form.

Please answer all of the questions below and return this form to the Chevron Phillips Employee Service Center in the enclosed postage-paid envelope.

If you do not provide this information, your medical and dental claims may be delayed until this information is received.

Please note that the information requested applies to your new health care plan elections. Please sign and date the form for our records.

Employee Name: _____

Employee Social Security Number: _____

Are any members of your family enrolled in another group or employer-sponsored health plan? (*check one*) yes ☐ no ☐

If yes, in whose name is the insurance carried? _____

Please indicate the name of the other insurance company: _____

Please indicate the effective date of coverage: _____

Which family members are enrolled under another plan for medical coverage? (*Please list the names of enrolled family members.*) _____
_____
_____

Which family members are enrolled under another plan for dental coverage? (*Please list the names of enrolled family members.*) _____
_____
_____

Employee Signature: _____ Date: _____

Make a copy of this form for your records and send the original to:

Chevron Phillips Benefits Service Center, P.O. Box 744941, Houston, TX 77274