



Coordination of Benefits (COB) Questionnaire Form

Goodyear Employee/Retiree Name _____

Social Security Number _____ - _____ - _____

Spouse's Name _____

Social Security Number _____ - _____ - _____

Is there a previous COB form on file?

Yes No

If a revised COB form, what is the effective date of the change in coverage? _____

The "Working Spouse" provision applies to spouses and dependents of Goodyear employees and retirees who have access to another employer-sponsored health plan through their employer (or former employer if retired). Payments allowable under Goodyear's medical and prescription drug program will be coordinated with the spouse's or dependent's available coverage, whether or not they are actually enrolled.

1. To determine "comparable coverage" you should look at deductibles, coinsurance, prescription drug coverage, monthly contributions for coverage, etc. and choose the most comparable.
2. If prescription drug coverage is separate from medical, you should also elect prescription drug coverage. Goodyear will be secondary on prescription drugs as long as it is available to the spouse/dependent.
3. If monthly premium is over \$200, you must still fill out the form. Unless you are notified by the Company, Goodyear will coordinate all medical and prescription drug claims as if the spouse/dependent had elected their coverage.
4. Cost is the Employee's/Retiree's cost, after deducting their employer's contribution or flexible credits. Money that would have been provided to the spouse/dependent to "opt out" or to not be covered under their employer's plan is not eligible for reimbursement.
5. Dependents are not required to take dental or vision if they are separate elections.
6. Dependents will not be reimbursed for dental or vision coverage if elected (separate from medical coverage) through their employer.
7. This rule applies only to medical coverage that is accessible to the dependent through their own employment. It does not apply to independent insurance policies purchased by the dependent.

DOES YOUR SPOUSE/DEPENDENT WORK 32 HOURS OR MORE ON AVERAGE PER WEEK AND HAVE ACCESS TO EMPLOYER-SPONSORED HEALTHCARE?

YES (Go to next question)

NO (Skip to Verification section on the reverse side of this form)

IS YOUR SPOUSE RETIRED AND HAVE ACCESS TO EMPLOYER-SPONSORED HEALTHCARE?

YES (Go to next question)

NO (Skip to Verification section on the reverse side of this form)

Complete and return both sides of this form to

The Goodyear Benefit Solution Center

POBox 52040

Phoenix AZ 85072-2040

If you have any questions please contact the Benefit Solution Center at 1-800-334-9395.



Is your spouse employed by (or retired from) Goodyear or one of its affiliated companies? ___ Yes ___ NO

If form is being filled out for a dependent other than a spouse, is this individual currently being claimed as a dependent by the Goodyear employee or retiree on their income tax form? ___ Yes ___ NO

This is to certify that my spouse/dependent (Name) _____ does have access to medical coverage through an employer or former employer (fill in additional information below) effective _____:

Cost to the Employee or Retiree for Single Coverage \$ _____/Monthly
(if prescription drug is separate charge, please include)

Plan Coverage _____ (Please describe)
(i.e. \$175 deductible, 15% copay, \$750 out of pocket maximum, prescription coverage)

Group Number _____

Carrier _____

Is this the only plan available to you? ___ Yes ___ NO

Other Plans available _____ (please describe)

Employer _____

Employer Address: _____

Human Resource Contact Name _____

Contact Phone Number _____

VERIFICATION

I hereby understand I am personally liable for any benefits paid should any of the above information be inaccurate.

I understand it is my responsibility to notify the Goodyear Benefit Solution Center within 31 days in the event that any changes occur in the status of the above named dependent.

Employee Social Security Number _____

Employee/Retiree Signature _____ Date _____