Coordination of Benefits Questionnaire

Please Print

Subscriber's Name: _____ Identification Number _____
Last *First* *Middle Initial*

Subscriber's Social Security Number: _____ Spouse's Social Security Number: _____

In addition to your Blue Cross and Blue Shield coverage, are you, your spouse or dependent children covered by another group health insurance plan or Medicare? ☐ **Yes** If yes, please complete the entire questionnaire below, sign and return to us. ☐ **No** If no, please complete the question below, sign and return to us.

If you had other health insurance coverage which cancelled when your **Blue Cross and Blue Shield** coverage became effective, please provide
Name of carrier or plan _____ and Cancellation Date ____/____/____
Mo. *Day* *Yr.*

Other Health Insurance:
If Multiple Coverage Exists, Please List On A Separate Sheet of Paper

1. Policy Holder's Name: _____ Sex: ☐ Male ☐ Female

2. Policy Holder's Social Security Number: _____ Date of Birth: ____/____/____
Mo. *Day* *Yr.*

3. Name of Employer providing coverage: _____

4. Name of Other Insurance Company: _____ Policy Number: _____

5. Address of Other Insurance Company: _____ Phone Number: _____

6. Effective Date of Policy: ____/____/____ Cancellation Date of Policy (If Applicable): ____/____/____
Mo. *Day* *Yr.* *Mo.* *Day* *Yr.*

7. Policy Covers: Policy Holder Only _____ Two Persons _____ Family _____

_____ _____
Name *Relationship to Policy Holder*

_____ _____
Name *Relationship to Policy Holder*

_____ _____
Name *Relationship to Policy Holder*

8. Services Covered:
A. Hospital Services ☐ Yes ☐ No
B. Physician Services ☐ Yes ☐ No
C. Dental Coverage ☐ Yes ☐ No
D. Major Medical (Out of pocket expenses not otherwise covered) ☐ Yes ☐ No
E. Eye or Vision Care ☐ Yes ☐ No
F. Catastrophic Benefits Only ☐ Yes ☐ No

To be completed for dependents whose natural parents live apart and who provide medical coverage for these dependents. Please indicate relationship to children (natural mother, natural father, step-father). If multiple children, please list on a separate sheet of paper.

	Parent's Name	*Relationship to Child*	*Child's Name*	*Child's Date of Birth*
Parent With Custody Of Child(ren)				
Parent With Court Assigned Responsibility For Child(ren)s Medical Expenses				

9. Do you or any of your dependents have Medicare? Yes ☐ No ☐ If Yes, please complete the following:

Participant's Name	**Birthdate**	**Medicare Hic Number**	**Hospital (Part A) Effective Date**	**Hospital (Part B) Effective Date**

Eligible for Medicare as a result of (check one) ☐ Age ☐ Disability ☐ End Stage Renal Disease

Beginning date of renal treatment: ____/____/____
Mo. *Day* *Yr.*

Participant Actively Employed ☐ Yes ☐ No

Spouse Actively Employed ☐ Yes ☐ No

Subscriber's Signature _____ Date _____ Work Phone Number _____

Home Phone Number _____

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