Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

COORDINATION OF BENEFITS INFORMATION

Your prompt response will ensure that your claims are paid timely and accurately
This form does not add or remove members on your BCBSM contract.
It is only intended to gather other health information about those covered under BCBSM.

PLEASE PRINT

BCBSM Subscriber		
New Address only:		
City	State	Zip
Subscriber's Policy Number		
Subscriber's Group Number		

1. Are you, your spouse or any of your dependents covered under any other health care policy, including Medicare or another Blue Cross Blue Shield contract?

☐ NO - COMPLETE THIS SECTION & ANSWER #2 ☐ YES - COMPLETE SECTIONS 1, 2, 3 & 4 (over)

Spouse's Name (first & last) _____

Spouse's Social Security Number _____ Birth Date _____

Your Phone Number _____ If we need to, when is the best time to call you? (Check one) ☐ Morning ☐ Afternoon ☐ Evening

Subscriber's Signature _____ Today's Date _____

2. Did you or anyone on your contract previously have group health coverage that's been cancelled?

☐ NO ☐ YES - COMPLETE THIS SECTION

Insurance Co. Name _____ Date Cancelled _____

3. Which of your family members are covered under this other plan? (include yourself if you too, are covered)

☐ You ☐ Your Spouse ☐ The Dependent Children Listed below

Name (first & last)	Relationship to Other Policy Holder	Relationship to Above BCBSM Subscriber
1.	☐ Natural Child ☐ Stepchild ☐ Other (list)	☐ Natural Child ☐ Stepchild ☐ Other (list)
2.	☐ Natural Child ☐ Stepchild ☐ Other (list)	☐ Natural Child ☐ Stepchild ☐ Other (list)
3.	☐ Natural Child ☐ Stepchild ☐ Other (list)	☐ Natural Child ☐ Stepchild ☐ Other (list)
4.	☐ Natural Child ☐ Stepchild ☐ Other (list)	☐ Natural Child ☐ Stepchild ☐ Other (list)

Please explain the other health insurance information which covers the people identified above. (This includes listing other BCBSM contracts that cover someone on your contract)

Other Policy Holder Name (first & last) _____ Birth date _____

SSN _____ Policy Holder is: ☐ Actively Working ☐ Retired ☐ Other

Insurance Co. Name: _____ Effective date of coverage _____

Street address _____

City _____ State _____ Zip Code _____ Phone _____

Policy/ID Number _____ Group number _____

Employer Name _____ Month/Year Hired _____

Check all of the appropriate boxes:

Contract Size: ☐ Single ☐ Family **Coverage Type:** ☐ HMO ☐ PPO ☐ Traditional ☐ Medicare

Benefits Covered: ☐ Hospital ☐ Medical ☐ Drugs ☐ Vision ☐ Hearing ☐ Dental

4. Are any of the children on your contract covered under a divorced or separated parent's health plan?

☐ NO - PLEASE RETURN THIS FORM ☐ YES - PLEASE COMPLETE THE FOLLOWING SECTIONS

Children's first and last names	and	Who has physical custody?	Mom	Dad	Other
1. _____	and	_____	☐	☐	☐
2. _____	and	_____	☐	☐	☐
3. _____	and	_____	☐	☐	☐
4. _____	and	_____	☐	☐	☐
5. _____	and	_____	☐	☐	☐

Who is Responsible for the Child's health care coverage?	You	Section 3 Policy Holder	Policy Holder listed below	Court Order Yes*	Court Order No
Child's Name _____	☐	☐	☐	☐	☐
Child's Name _____	☐	☐	☐	☐	☐
Child's Name _____	☐	☐	☐	☐	☐
Child's Name _____	☐	☐	☐	☐	☐
Child's Name _____	☐	☐	☐	☐	☐

*** If responsibility is determined by a Court Order, please attach a copy of the sections of the Court Order which deal specifically with custody and health care responsibility.**

Additional Insurance Information for dependent Children

Name _____ Relationship to Child _____

Social Security Number _____ Birth Date _____

Name of Health Insurance Providing Child's Coverage _____

Street Address _____

City _____ State _____ Zip code _____ Phone _____

Policy Number _____ Group Number _____ ID Number _____

Effective date of coverage _____ Type of plan: ☐ Hospital ☐ Medical ☐ Both

Please note: If other dependent children are covered by another individual's health care coverage, or the above children are covered under a third Health Care Policy, we need the same type of information (requested above) for each Health Care Policy. (If additional space is needed, please attach a separate sheet).

Attn: Local COB Membership - B340
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-9942

For your convenience, you can now update your coordination of benefits information on the secured Blue Cross Blue Shield of Michigan website at: https://secure.bcbsm.com/mmcob/cobFormServlet.
You may also reach us toll free at (866) 611-7474.