BlueCross BlueShield of Delaware

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COORDINATION OF BENEFITS QUESTIONNAIRE

Your BCBSD ID Number: _____

A. Do any of your children have other health coverage? Please check one:

_____ No If no, please check this line, sign this form at the bottom, write in your BCBSD ID number above, and return it in the enclosed postage paid envelope.

_____ Yes If yes, please fill out Sections B and C, then sign this form at the bottom, write in your BCBSD ID number, and return it in the enclosed postage paid envelope.

B. Please fill out this section concerning your child or children's other coverage

_____ Another Blue Cross Blue Shield of Delaware contract. I.D. Number: _____

_____ Another HEALTH insurer:

Name of the other health insurance company: _____

Name of policyholder: _____ Birthdate: _____

Name of employer: _____

Effective date of policy: _____/_____/_____; if cancelled, date: _____/_____/_____

Names of those covered:

_____ Dependent Child _____ Dependent Child _____ Dependent Child

_____ Dependent Child _____ Dependent Child _____ Dependent Child

If divorced, who has primary, physical custody? (circle one) MOTHER FATHER

C. Does the other coverage as shown in Section B include a prescription drug program? ___ Yes ___ No

Name of drug plan: _____

We thank you for your time spent completing this questionnaire. The information you have provided will help us process your claims.

Your Signature: _____ Daytime Telephone Number: _____

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