Blue Cross Blue Shield of Michigan

COORDINATION OF BENEFITS QUESTIONNAIRE

If you, your spouse or any of your covered dependents do not have any other health insurance, call our automated response number at **1-866-263-9494.** If there is other health coverage, you can update your coordination of benefits information at **bcbsm.com/cob** or complete this form.

SECTION 1 YOUR BCBSM INFORMATION

BCBSM enrollee name (as found on your ID card)	BCBSM enrollee ID / contract number

Are you, your spouse or any of your dependents covered by another health plan other than Medicare?

☐ NO – Please skip the rest of the questions, sign the bottom of this form and return.

☐ YES – Please complete the entire form, sign the bottom of this form and return.

SECTION 2 OTHER HEALTH COVERAGE INFORMATION

Please provide the following information about the policyholder of the other health coverage. Attach additional pages if needed.

Name of policyholder of other coverage	Relationship to you	Employer	Birth date

Insurance company name	Insurance company city	State	Phone number

Enrollee ID / policy number	Group number	Effective date	Cancellation date (if applicable)

Type of coverage ☐ Single ☐ Family

Is this a retiree contract? ☐ Yes ☐ No
Is this a COBRA contract? ☐ Yes ☐ No
Is policy holder laid-off? ☐ Yes ☐ No

Type of plan: (check all that apply) ☐ Medical ☐ Prescription drugs ☐ Dental ☐ Medicare Advantage

Who is covered by this other plan? Include yourself if applicable.

Name (first and last)	Relationship to you	Name (first and last)	Relationship to you
1.		4.	
2.		5.	
3.		6.	

SECTION 3 SPECIAL SITUATIONS

Fill out this section only if your children have health care coverage in addition to the above because of divorce, separation or court order.

Is there a court order that determines responsibility for health care coverage or custody? ☐ No ☐ Yes *(attach a copy of the sections that apply to health care responsibility and/or custody arrangements)*

Name of person responsible for child's health care coverage	Employer	Birth date

Insurance company name	Insurance company city	State	Phone number

Enrollee ID / policy number	Group number	Effective date	Cancellation date (if applicable)

Which children are covered by this insurance?

Child's name (first and last)	Who has custody	Child's name (first and last)	Who has custody
1.		4.	
2.		5.	
3.		6.	

Subscriber's signature: _____ **Date:** _____

Return completed forms to: COB Membership — 610J
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-9942

OR Fax: 866-581-3946