Blue Cross Blue Shield of Michigan

COORDINATION OF BENEFITS QUESTIONNAIRE

LOCAL

For your convenience, you can update your coordination of benefits information online at **bcbsm.com/cob**. **If neither you nor your covered dependents have any additional group health coverage, simply call our automated response number at 866-611-7474.**

SECTION 1 YOUR BCBSM INFORMATION

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

In addition to this BCBSM contract, are you or any of your covered dependents also covered by another group health care plan other than Medicare? If you have additional BCBSM contracts, please include this as other coverage.

☐ NO – Please skip the rest of the questions, sign at the bottom and return

☐ YES – Please complete entire form, sign at the bottom and return

SECTION 2 OTHER HEALTH COVERAGE INFORMATION

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

Name of policy holder of other coverage	Relationship to you	Social security number	Employer	Birth date

Insurance company name	Insurance company street address	City	State	ZIP code

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) ☐ Hospital ☐ Medical ☐ Dental ☐ Drugs

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 any of your children have health care coverage in addition to the above because of divorce, separation, etc.

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	Social security number	Employer	Birth date

Insurance company name	Insurance company street address	City	State	ZIP code

Enrollee ID / policy number	Group number	Effective date	Cancellation date

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 — 0526
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-9942

OR Fax: 866-581-3946