

State of Delaware  
Office of Management and Budget, Statewide Benefits Office

**Dependent Coordination of Benefits Form**

**Section A:**

Member Name: \_\_\_\_\_

Member ID Number or Social Security Number: \_\_\_\_\_

Do any of your children have other health care coverage?

\_\_\_\_\_ No...please check this line, sign this form at bottom, and return it in enclosed postage paid envelope.

\_\_\_\_\_ Yes...please complete Sections B and C below, sign this form at bottom, and return it in enclosed postage paid envelope.

**Section B:**

Please complete this section concerning your child/ren's other coverage. If all children have the same coverage, please list each child's name; if children have different coverage, please prepare a separate form for each child.

\_\_\_\_\_ Child/ren is covered by another Aetna plan and ID Number is \_\_\_\_\_

\_\_\_\_\_ Child/ren is covered by another health insurance plan.

Name of the other health insurance plan is \_\_\_\_\_

Name of policyholder: \_\_\_\_\_ Birth date \_\_\_\_\_

Name of employer \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Date, if cancelled: \_\_\_\_\_

Names of child/ren covered and birth date:

Child: \_\_\_\_\_

Child: \_\_\_\_\_

Child: \_\_\_\_\_

If divorced, which parent has primary, physical custody? \_\_\_\_\_ Mother \_\_\_\_\_ Father

**Section C:**

Does the other coverage, as indicated in Section B, include a prescription drug program?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Thank you for completing this form, your responses will enable claims to be processed properly.

Your signature: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_

Please print this form, complete, and send by U.S. Mail to:

Aetna Inc.  
1425 Union Meeting Road – U21S  
Blue Bell PA 19422