HIGHMARK Delaware

COORDINATION OF BENEFITS QUESTIONNAIRE

Your Name: ______________________________ Social Security #: ____________________

A. Within the past year, have you or any member of your family been covered by another insurance company?

❑ **No.** Please complete question C, if applicable.

❑ **Yes.** Please complete the remainder of this questionnaire.

B. Check which of the following plans provide benefits for you or any member of your family:

❑ **Another Highmark Blue Cross Blue Shield Delaware contract?**

ID #: ______________________________

❑ **Medicare?**

HIC #: ______________ Part B effective date (mo., day, yr.): ______________________________

❑ **Another health insurer?**

Name of other health insurance company: ______________________________

Name of other employer: ______________________________

Address where claims are submitted: ______________________________

Name of policyholder: ______________________________

Policyholder's date of birth (month, day, year): ______________________________

Policyholder's ID #: ______________________________

Effective date of policy (month, day, year): ______________________________

Cancellation date, if applicable (month, day, year): ______________________________

Name of persons covered:

Spouse: ______________________________

Dependent child(ren): ______________________________

❑ **Another dental policy?**

Name of dental carrier: ______________________________

Effective date of dental policy (month, day, year): ______________________________

If dental policy is canceled, date (month, date, year): ______________________________

Who is covered under this policy? ❑ Policyholder ❑ Spouse ❑ Dependent child(ren)

continued on reverse side

COORDINATION OF BENEFITS QUESTIONNAIRE continued

C. The following information must be provided as required by our Employer's Coordination of Benefits (COB) Policy. (Check with your employer.)

My spouse is:
- ❑ Not employed
- ❑ Employed full-time
- ❑ Employed part-time
- ❑ Self-employed
- ❑ Retired

Name of spouse's employer: ____

Is medical insurance offered? ❑ Yes ❑ No

Percent of premium, if any, paid by spouse? ____

If spouse is self-employed, what percent is paid by his/her employees? __________________________

Renewal date of spouse's medical insurance plan: ____

Your signature: ____

Daytime telephone number: (   ) ____________________________

Identification #: ____

Please return this survey to:
Highmark Delaware
P.O. Box 1991
Wilmington, DE 19899-1991

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

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association