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: _____Birthdate_____

Name of employer _____

Effective date of coverage: _____ Date, if cancelled: _____

Names of child/ren covered and birthdate:

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: _____