



An Independent Licensee of the Blue Cross and Blue Shield Association

Coordination of Benefits (COB) Subscriber Questionnaire

It is important that you complete and return this survey. COB is a way to coordinate benefit payments when you or your dependents are covered by more than one health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

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

Yes No

If yes: – For other health insurance plans, please complete sections 1 & 2.
– For Medicare coverage only, please complete sections 1 & 3.
– For other health insurance plans and Medicare, complete sections 1, 2 & 3.

If no: – Please complete section 1 and sign your name.

PLEASE PRINT

SECTION 1 – TO BE COMPLETED BY ALL HMSA SUBSCRIBERS			
HMSA Subscriber's Name	Birth Date	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Date of Retirement (If Applicable)
HMSA Member Number	Social Security Number	Phone Number	
I certify that the information furnished by me on this form is true and correct at this time, and agree to inform HMSA of any changes.			
HMSA Subscriber's Signature			Today's Date

SECTION 2 – OTHER COVERAGE INFORMATION				
Name of Policyholder	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Social Security Number	Relationship to You
Name of Other Health Plan	Policyholder Identification Number			
Other Health Plan's Address			Phone Number	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Employer's Name		Date of Retirement (If Applicable)	
Type of Coverage	<input type="checkbox"/> Medical	<input type="checkbox"/> Drug	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
Effective Date	_____	_____	_____	_____
Cancellation Date	_____	_____	_____	_____
Please list any other dependents covered by this other plan. If there are more than four, please check this box <input type="checkbox"/> and list the rest on the back of this form.				
1. Name (First and Last)	Relationship to You	3. Name (First and Last)	Relationship to You	
2. Name (First and Last)	Relationship to You	4. Name (First and Last)	Relationship to You	

SECTION 3 – MEDICARE COVERAGE INFORMATION		
Name of Medicare Beneficiary		Social Security Number
Medicare Number	Type of Coverage Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	Medicare Eligibility Due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease Initial Dialysis Date: _____
Name of Medicare Beneficiary		Social Security Number
Medicare Number	Type of Coverage Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	Medicare Eligibility Due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease Initial Dialysis Date: _____