Coordination of Benefits Form

An Independent Licensee of the Blue Cross and Blue Shield Association

If you and your dependents have more than one health plan, completing this form will help us process your claims quickly and accurately. You can also complete this form online at hmsa.com. Go to My Account Login and click Coordination of Benefits in the Forms drop-down menu.

Check the box that fits your situation and complete the sections indicated.

- ☐ **Only HMSA.** Check this box if you, your spouse, and your dependents are enrolled **only** in your HMSA plan. Then complete section 1 only.
- ☐ **HMSA and another health insurance plan.** Check this box if you, your spouse, or any of your dependents are enrolled in your HMSA plan **and** another health insurance plan. Then complete sections 1 and 2.
- ☐ **HMSA and Medicare.** Check this box if you, your spouse, or any of your dependents are enrolled in your HMSA plan **and** Medicare. Then complete sections 1 and 3.
- ☐ **HMSA, another health insurance plan, and Medicare.** Check this box if you, your spouse, or any of your dependents are enrolled in your HMSA plan, another health insurance plan, **and** Medicare. Then complete sections 1, 2, and 3.

PLEASE PRINT

Section 1 – HMSA Subscriber Information

HMSA subscriber's name: _____ Birth date: _____

Employment status: ☐ Active ☐ COBRA ☐ Retired Retirement date (if applicable): _____

Employer's name: _____ Employer's phone no.: (_____)_____

Employer's address: _____

HMSA subscriber ID no.: _____ Social Security no.: __ __ __-__ __-__ __ __ __

Phone no.: (_____) _____

I certify that the information I've provided on this form is true and correct. I agree to inform HMSA of any changes.

HMSA subscriber's signature: _____ Date: _____

Section 2 – Other Coverage Information

Policyholder's name: _____ Birth date: _____

Sex: ☐ Male ☐ Female

Relationship to you: _____ Social Security no.: __ __ __-__ __-__ __ __ __

Other health plan's name: _____ Policyholder ID no.: _____

Other health plan's address: _____

Phone no.: (_____) _____

Employment status: ☐ Active ☐ COBRA ☐ Retired Retirement date (if applicable): _____

Employer's name: _____ Employer's phone no.: (_____)_____

Employer's address: _____

Type of coverage	☐ Medical	☐ Drug	☐ Dental	☐ Vision
Effective date				
Cancellation date				

Please list any other dependents who are on the other plan.

1. First and last names: _____
   Relationship to you: _____
2. First and last names: _____
   Relationship to you: _____
3. First and last names: _____
   Relationship to you: _____
4. First and last names: _____
   Relationship to you: _____
5. First and last names: _____
   Relationship to you: _____
6. First and last names: _____
   Relationship to you: _____
7. First and last names: _____
   Relationship to you: _____
8. First and last names: _____
   Relationship to you: _____

Section 3 – Medicare Coverage Information

Medicare beneficiary's name:

_____

Social Security no.:___ ___ ___-___ ___-___ ___ ___ ___

Medicare no.: _____

Type of coverage	Effective date
Part A (Hospital)	
Part B (Medical)	
Part D (Drug)	

Medicare eligibility due to:

☐ Age
☐ Disability
☐ End-stage renal disease
- Initial dialysis date: _____

Medicare beneficiary's name:

_____

Social Security no.:___ ___ ___-___ ___-___ ___ ___ ___

Medicare no.: _____

Type of coverage	Effective date
Part A (Hospital)	
Part B (Medical)	
Part D (Drug)	

Medicare eligibility due to:

☐ Age
☐ Disability
☐ End-stage renal disease
- Initial dialysis date: _____

Please mail your completed Coordination of Benefits Form to:

HMSA
MS Primacy
P.O. Box 860
Honolulu, HI 96808-0860