



COORDINATION OF BENEFITS QUESTIONNAIRE

If you, your spouse or any of your covered dependents do not have any other health insurance, call our automated response number at **1-866-263-9494**. If there is other health coverage, you can update your coordination of benefits information at **bcbsm.com/cob** or complete this form.

SECTION 1 YOUR BCBSM INFORMATION			
BCBSM enrollee name (as found on your ID card)	BCBSM enrollee ID / contract number		
<p>Are you, your spouse or any of your dependents covered by another health plan other than Medicare?</p> <p> <input type="checkbox"/> NO – Please skip the rest of the questions, sign the bottom of this form and return. <input type="checkbox"/> YES – Please complete the entire form, sign the bottom of this form and return. </p>			
SECTION 2 OTHER HEALTH COVERAGE INFORMATION			
<i>Please provide the following information about the policyholder of the other health coverage. Attach additional pages if needed.</i>			
Name of policyholder of other coverage	Relationship to you	Employer	Birth date
Insurance company name	Insurance company city	State	Phone number
Enrollee ID / policy number	Group number	Effective date	Cancellation date (if applicable)
Type of coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Is this a retiree contract? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this a COBRA contract? <input type="checkbox"/> Yes <input type="checkbox"/> No Is policy holder laid-off? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of plan: (check all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Dental <input type="checkbox"/> Medicare Advantage	
<i>Who is covered by this other plan? Include yourself if applicable.</i>			
<u>Name (first and last)</u>	<u>Relationship to you</u>	<u>Name (first and last)</u>	<u>Relationship to you</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____
SECTION 3 SPECIAL SITUATIONS			
<i>Fill out this section only if your children have health care coverage in addition to the above because of divorce, separation or court order.</i>			
Is there a court order that determines responsibility for health care coverage or custody? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(attach a copy of the sections that apply to health care responsibility and/or custody arrangements)</i>			
Name of person responsible for child's health care coverage	Employer		Birth date
Insurance company name	Insurance company city	State	Phone number
Enrollee ID / policy number	Group number	Effective date	Cancellation date (if applicable)
<i>Which children are covered by this insurance?</i>			
<u>Child's name (first and last)</u>	<u>Who has custody</u>	<u>Child's name (first and last)</u>	<u>Who has custody</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Subscriber's signature: _____ **Date:** _____

Return completed forms to: Amber Curtis, Benefits Specialist 517-264-3870
 Adrian College acurtis@adrian.edu
 110 S Madison St
 Adrian, MI 49221