

Coordination of Benefits Form

UT SELECT Group No. 71778

Member Name: _____ Social Security No. _____ - _____ - _____
(please print)

Your Blue Cross and Blue Shield contract contains a Coordination of Benefits provision. Processing of claims submitted under your contract are dependent upon your response.

PLEASE RESPOND TO THIS QUESTIONNAIRE WITHIN FOURTEEN DAYS

Are you or any member of your family that is currently covered by your Blue Cross and Blue Shield plan also covered by another health or dental insurance policy or Medicare?

- No If 'No' was checked, please sign and return this questionnaire to us.
 Yes If 'Yes' was checked, please complete all of the following:

a. Check all that apply:

- Health Dental Group Coverage (employment or professional organization) Champus
 Individual policy Student policy Sport policy Medicare Part A and/or Part B Other _____

b. Other Insurance Carrier's name: _____
 Address: _____
 City, State, Zip code: _____ Phone: (____) _____ - _____

c. Other Insurance Policyholder's name: _____ Policyholder's birthdate: _____
 Identification or Certificate Number: _____
 Effective date: _____ Cancelled date: _____
 Policyholder is: Actively working Inactive Retired as of / / COBRA as of / /

d. Other Insurance Employer's name: _____
 Employers address: _____
 City, State, Zip code: _____ Phone (____) _____ - _____

Please complete the following information for all family members covered by other insurance and/or Medicare.
 If necessary, use a separate piece of paper to list any additional policies.

| Name (First and Last) | Birthdate MMDDYYYY | Social Security # and HIC # (if applicable) | Medicare Effective Date | Reason(s) for Entitlement * | Medicare Cancel Date |
|-----------------------|-----------------------|------------------------------------------------|----------------------------|--------------------------------|-------------------------|
| Self | | | Part A Part B | | Part A Part B |
| Spouse | | | Part A Part B | | Part A Part B |
| Dependent | | | Part A Part B | | Part A Part B |
| Dependent | | | Part A Part B | | Part A Part B |
| Dependent | | | Part A Part B | | Part A Part B |

* The Reason for Medicare Entitlement should be: attaining age 65, disability, or end stage renal disease.

Your employer and your Blue Cross and Blue Shield Plan appreciate your prompt reply.

Signature: _____ Date: _____



**BlueCross BlueShield
of Texas**

Return completed form to: Blue Cross and Blue Shield of Texas
 P.O. Box 660044
 Dallas, TX 75266-0044