



Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Coordination of Benefits

Providing this information will allow us to coordinate your coverage with other coverage you may have. It will also help maximize your benefits.

| | | | |
|---|------------------|--|----------------------------|
| Subscriber Name | | BCN Advantage Contract Number | Medicare ID Number |
| Address | | | |
| City | | State | Zip Code |
| Section 1 Employment Status | | | |
| Are you actively working? Yes <input type="checkbox"/> No <input type="checkbox"/> | | Are you self-employed? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Are you on disability or medical leave? Yes <input type="checkbox"/> No <input type="checkbox"/> | | If yes, what was last day worked? _____ | |
| Are you retired? Yes <input type="checkbox"/> No <input type="checkbox"/> | | If yes, what was your retirement date? _____ | |
| Do you plan to retire in the next year? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| Name of Employer | | Address of Employer | |
| Does your employer have more than 20 employees? Yes <input type="checkbox"/> No <input type="checkbox"/> | | Does your employer have more than 100 employees? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Section 2 Your Additional Coverage | | | |
| Do you have other health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If no, go to Section 3.</i> | | | |
| Policy Holder's Name | | Date of Birth | Relationship to Subscriber |
| Employer's Name | | Name of Health Insurance Carrier | |
| Effective Date | Termination Date | Phone Number on Card | |
| Is this an active or retiree policy? <input type="checkbox"/> Active <input type="checkbox"/> Retiree | | Group Number | Policy Number |
| Section 3 Marital Status | | | |
| Do you have a spouse? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If no, go to Section 5.</i> | | | |
| Is your spouse actively working? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| Is your spouse on disability or medical leave? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| If yes, what was the last day worked? _____ | | | |
| Is your spouse retired? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| If yes, what was the retirement date? _____ | | | |
| Does your spouse plan to retire in the next year? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| Name of Spouse's Employer | | Address of Spouse's Employer | |
| Does your spouse's employer have more than 20 employees? Yes <input type="checkbox"/> No <input type="checkbox"/> | | Does your spouse's employer have more than 100 employees? Yes <input type="checkbox"/> No <input type="checkbox"/> | |

Section 4 Your Spouse's Additional CoverageDoes your spouse have other health insurance? Yes No *If no, go to Section 5.*

| | | | |
|---|------------------|--|---------------|
| Policy Holder's Name | Date of Birth | Relationship to BCN Advantage Subscriber | |
| Employer's Name | | Name of Health Insurance Carrier | |
| Effective Date | Termination Date | Phone Number on Card | |
| Is this an active or retiree policy? <input type="checkbox"/> Active <input type="checkbox"/> Retiree | | Group Number | Policy Number |

Section 5 Prescription Drug CoverageDo you have other prescription coverage? Yes No *If no, go to Section 6.*

| | | | |
|--|------------------------------|----------------------------------|--------------|
| Policy Holder's Name | Date of Birth | Relationship to Subscriber | |
| Employer's Name | | Name of Health Insurance Carrier | |
| Contract Number | Effective Date | Termination Date | Phone Number |
| Rx Group Number | Rx PCN (on front of Rx card) | Rx BIN (on front of Rx card) | |
| Is this supplemental prescription drug coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| If yes, type: <input type="checkbox"/> Tricare <input type="checkbox"/> Medigap <input type="checkbox"/> State Pharmaceutical Assistance Program (SPAP) <input type="checkbox"/> Other | | | |

Section 6 Additional Health Insurance Information

- 1) Are YOU receiving Black Lung benefits? Yes No
- 2) Are YOU receiving Workers' Compensation benefits? Yes No
- 3) Are YOU receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? Yes No

If you answered YES to any question in this section, please complete the following:

| | | | |
|------------------|------------------------|-----------------------------------|----------------|
| Employer's Name | | Name of Responsible Party/Carrier | |
| Phone Number | Address of Carrier | | Effective Date |
| Termination Date | Policy or Claim Number | Name of Attorney | Phone Number |

| | | |
|----------------|--------------|------|
| Your Signature | Phone Number | Date |
|----------------|--------------|------|

If your answers to these questions change at any time, please contact BCN Advantage at 1-800-450-3680 from 8 a.m. to 8 p.m., seven days a week. TTY users should call 1-800-430-3211.

BCN Advantage HMOSM is a health plan with a Medicare contract.