

## Coordination of Benefits Subscriber Questionnaire

*Please Print*

Subscriber Name		BCN Contract Number	
Address	City	State	Zip

In addition to your Blue Care Network health coverage, are you or any of your dependents currently covered by any other health, Medicare or prescription coverage?

**No** If **NO**, please sign and date form.                       **Yes** If **YES**, please complete questionnaire.

If your dependents are covered by more than one insurance carrier; Blue Care Network is required by law to comply with any legal documentation regarding your dependent(s) on the Blue Care Network policy whose health care coverage is mandated by a court order from the Friend of the Court or a divorce decree.

**You must enclose a copy of this documentation for each child on your policy. Information required are the sections showing:**  
**(a) defendant and plaintiff    (b) physical custody    (c) health care/medical coverage responsibility**

**Other Health**    **Medicare**    **Prescription**

Policy Holder's Name		Social Security Number		Relationship to BCN Subscriber		Date of Birth	
Employer's Name				Employer's Phone Number (     )			
Name of Health Insurance Carrier		Phone Number (     )		Is this an Active or Retiree Policy? <input type="checkbox"/> Active <input type="checkbox"/> Retiree   Date Retired: _____			
Address of Health Insurance Carrier			City		State		Zip
Contract Number		Group Number		Effective Date		Termination Date	

**Please list all Blue Care Network members who are covered under this plan:**

Name	Relationship to BCN Subscriber	Name	Relationship to BCN Subscriber
Name	Relationship to BCN Subscriber	Name	Relationship to BCN Subscriber
Name	Relationship to BCN Subscriber	Name	Relationship to BCN Subscriber

**Additional**    **Other Health**    **Prescription**

Policy Holder's Name		Social Security Number		Relationship to BCN Subscriber		Date of Birth	
Employer's Name				Employer's Phone Number (     )			
Name of Health Insurance Carrier		Phone Number (     )		Is this an Active or Retiree Policy? <input type="checkbox"/> Active <input type="checkbox"/> Retiree   Date Retired: _____			
Address of Health Insurance Carrier			City		State		Zip
Contract Number		Group Number		Effective Date		Termination Date	

**Please list all Blue Care Network members who are covered under this plan:**

Name	Relationship to BCN Subscriber	Name	Relationship to BCN Subscriber
Name	Relationship to BCN Subscriber	Name	Relationship to BCN Subscriber
Name	Relationship to BCN Subscriber	Name	Relationship to BCN Subscriber

**TO THE BEST OF MY KNOWLEDGE, ALL STATEMENTS ARE TRUE AND ACCURATE**

Signature	Phone number	Date
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