



February, 2011

Dear Subscriber:

Blue Cross Blue Shield of Michigan needs to update your information so we can coordinate your health care benefits and provide you the best service possible.

Please complete the questionnaire on the back of this letter to tell us whether you or any of your covered dependants have another health care plan in addition to your Michigan Blues plan. If you are covered by more than one Michigan Blues contract or have additional coverage from another state's Blue Cross Blue Shield plan, please include this information.

This questionnaire will help us coordinate your Michigan Blues benefits with any other health care coverage to determine which plan has primary responsibility for paying your claims.

Please complete and return the form within 15 days of your receipt of this letter. Mail directly to Blue Cross Blue Shield to the address on the bottom of the Coordination Of Benefits form or fax your form to 1-866-581-3946.

**If neither you nor your covered dependents have any additional health care coverage, you do not need to fill out this form. Simply call our automated response number at 1-866-611-7474.**

If you have questions, call the Customer Service number on back of your Blues ID card.

Thank you in advance for your response.

Sincerely,

A handwritten signature in cursive script that reads "Duwayne Mills".

Duwayne Mills  
Manager  
Auto National and Corporate COB Membership

## Blue Cross Blue Shield of Michigan Coordination of Benefits Questionnaire

LOCAL

If neither you nor your covered dependents have any additional health care coverage, you do not need to fill out this form. Simply call our automated response number at 1-866-611-7474. Or if you prefer, you can fill out Section 1, then sign and return the form.

Section 1 Your Michigan Blues information				
Enrollee name (as found on your Blues ID card)	Enrollee ID / contract number			
<p><b>In addition to this Michigan Blues contract, are you or any of your covered dependents also covered by another health care plan other than Medicare? (More than one Michigan Blues contract is considered additional coverage.)</b></p> <p style="text-align: center;"> <input type="checkbox"/> No – Please skip the rest of the questions, sign at the bottom and return.           <span style="margin-left: 200px;"><input type="checkbox"/> Yes – Please complete entire form, sign at the bottom and return.</span> </p>				
Section 2 Other health care coverage information				
<b>Please provide the following information about the policy holder of the other coverage. Attach additional pages if needed.</b>				
Name of policy holder of other coverage	Relationship to you	Social Security number	Employer	Birth date
Insurance company name	Insurance company street address	City	State	ZIP code
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"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Drugs		
<b>Who is covered by this other plan? Include yourself if applicable.</b>				
<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				
<b>Only fill out this section if any of your children have health care coverage in addition to the above because of a situation like divorce or separation.</b>				
Is there a court order that determines responsibility for health care coverage or custody? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If "Yes", attach a copy of the sections of the court order that apply to health care responsibility or custody arrangements.)</i>				
Name of person responsible for child's health care coverage	Social Security number	Employer	Birth date	
Insurance company name	Insurance company street address	City	State	ZIP code
Enrollee ID / policy number	Group number	Effective date	Cancellation date	
<b>Which children are covered by this insurance?</b>				
<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 form in the enclosed, postage-paid envelope or fax it to 1-866-581-3946.**

If you misplace your envelope, please send your form to:

Blue Cross Blue Shield of Michigan  
COB Membership — 0526  
600 E. Lafayette Blvd.  
Detroit, MI 48226-9942