NEBRASKA

P.O. Box 3248
Omaha, Nebraska 68180-0001
nebraskablue.com

Coordination of Benefits
(COB)
Omaha 390-1840
Toll Free 800-462-2924
Fax 402-392-4126

<date>

I.D. No.: <prefix/id#>
OC COQ

Dear Member:

At Blue Cross and Blue Shield of Nebraska, we're pleased to provide your health care coverage.

Your coverage contains a Coordination of Benefits (COB) provision. This provision applies when more than one insurance plan provides you and/or your covered family members with benefits. So we can better serve you, we need some additional information. ***Please complete this questionnaire and return it to us in the enclosed reply envelope within 30 days.***

As the insured member, are you:

☐ Employed ☐ Not employed ☐ Retired Date of Retirement: _____

Is your spouse:

☐ Employed ☐ Not employed ☐ Retired Date of Retirement: _____

If you, your spouse or dependent children are covered by other medical, dental or Medicare coverage please complete the applicable section(s) on page 2 of this form.

If no other insurance, please mark the box below.

No ☐ We/I have no other medical/dental insurance or Medicare coverage. ***(Sign and return this form.)***

I certify the information provided is complete to the best of my knowledge.

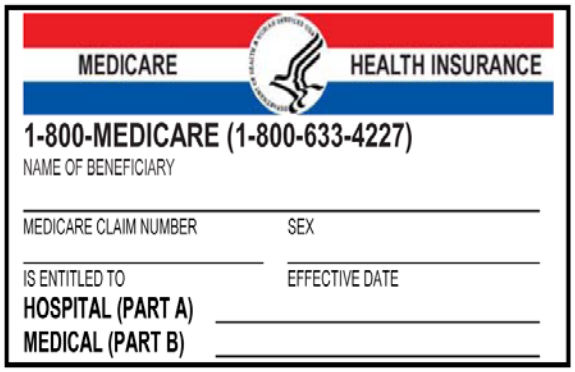
Signature _____ Date _____

Home Phone _____ Work Phone _____

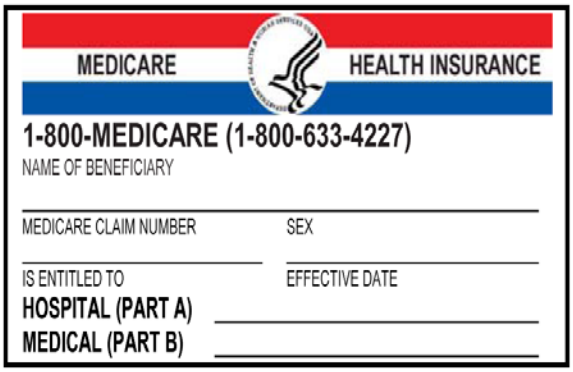
If you have any questions about this form, please call our Coordination of Benefits Department at one of the telephone numbers shown at the top of this letter.

Thank you for your business.

Section I
Medicare Information



Enter All The Information As It Appears On Your Medicare Card <u>For Each Covered Person</u>



I have Medicare because I am:
☐ 65 or older ☐ Disabled ☐ ESRD
I am: ☐ an Active Employee
☐ Retired: Date of Retirement: _____

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☐ 65 or older ☐ Disabled ☐ ESRD
I am: ☐ an Active Employee
☐ Retired: Date of Retirement: _____

Medicare Part D: ☐ YES ☐ NO
If Yes, Part D Carrier Name: _____
Phone No.: _____ Effective Date: _____

Section II
Other Insurance Information

_____ _____ _____
Name of Policyholder (first & last) Date of Birth Identification Number of Other Insurance

_____
Employer's Name Street Address City State Zip Code

_____
Name of Other Insurance Co. Address City State Zip Code Phone Number

Type of Coverage(s):
☐ Hospital ☐ Physician/Medical ☐ Prescription Drug ☐ Dental Effective Date: _____

TriCare Active Duty:
Standard Option Date: _____ Prime Option Date: _____ Retirement Date: _____

Type of Coverage: ☐ Single ☐ Family Insured's Social Security Number: _____

Name of member covered by this plan	Relationship	Date of Birth

<u>Child Custody Information</u>:

Insurance regulations stipulate which health plan will process claims first when coordinating benefits for dependent children whose parents are divorced, legally separated or never married. A court order could change who is the primary insurance.

Which parent has been ordered by the court to provide insurance? _____

***Please enclose a copy of the court order if we have not previously received it.**

Who has custody of the child(ren)? _____