Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

COORDINATION OF BENEFITS INFORMATION

Your prompt response will ensure that your claims are paid timely and accurately

PLEASE PRINT

☐ If new address, check here.

Name of Subscriber (First & Last)		
Subscriber's Address		
City	State	Zip
Subscribers's Social Security No.		
Subscribers's Group Number		

Complete this section when BCBSM is the only insurance for you and your dependents.

PART I :

Subscriber's name (first & last) _____

Subscriber's Social Security number _____ Birth date _____

Spouse's name (first & last) _____

Spouse's Social Security number _____ Birth date _____

Subscriber's signature _____ Today's date _____

Did you previously have Non-Blue Cross Blue Shield health coverage that was cancelled? Yes ☐ No ☐

If yes, indicate date cancelled _____

Complete this section if you or any dependents are also covered by another Health Insurance Policy. This includes another Blue Cross and Blue Shield Policy.

PART II: OTHER HEALTH INSURANCE POLICY (NON MEDICARE)

Subscriber Name with Other Insurance Policy _____ Birth date _____

Social Security number _____ Is this person actively employed? _____ Retired? _____

Name of other Health Insurance Policy _____ Effective date of coverage _____

Street address _____

City _____ State _____ Zip code _____ Phone _____

Policy number _____ Group number _____ ID number _____

Type of coverage (check one): Single ☐ Family ☐ Type of plan: Hospital ☐ Medical ☐ Both ☐

Employer providing coverage _____

Street address _____

City _____ State _____ Zip code _____

List family members covered by other plan:

Name (first & last)	Relationship to this subscriber	Relationship to BCBSM subscriber
1.		
2.		
3.		
4.		

Over please