HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

Coordination of Benefits (COB) Subscriber Questionnaire

It is important that you complete and return this survey. COB is a way to coordinate benefit payments when you or your dependents are covered by more than one health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

Are you, your spouse or any of your dependents covered by your HMSA plan also covered by any other group health Plan or Medicare?

☐ Yes ☐ No

If yes: — For other group health insurance plans, please complete sections 1 & 2.
— For Medicare coverage only, please complete sections 1 & 3.
— For other group heath and Medicare, complete sections 1, 2 & 3.

If no: — Please complete section 1 and sign your name.

PLEASE PRINT

SECTION 1—TO BE COMPLETED BY ALL HMSA SUBSCRIBERS		
HMSA Subscriber's Name	Employment Status ☐ Active ☐ Retired	Date of Retirement (If Applicable)
HMSA Member Number	Social Security Number	Phone Number
I certify that the information furnished by me on this form is true and correct at this time, and agree to inform HMSA of any changes.		
HMSA Subscriber's Signature		Today's Date

SECTION 2—OTHER COVERAGE INFORMATION				
Name of Policyholder	Sex ☐ M ☐ F	Birthdate	Social Security Number	Relationship to You
Name of Other Health Plan			Policyholder Identification Number	
Other Health Plan's Address			Phone Number	
Employment Status ☐ Active ☐ Retired	Employer's Name		Date of Retirement (If Applicable)	

Type of Coverage	☐ Medical	☐ Drug	☐ Dental	☐ Vision
Effective Date				
Cancellation Date				

Please list any other dependents covered by this other plan. If there are more than four, please check this box ☐ and list the rest on the back of this form.

1. Name (First and Last)	Relationship to You	3. Name (First and Last)	Relationship to You
2. Name (First and Last)	Relationship to You	4. Name (First and Last)	Relationship to You

SECTION 3—MEDICARE COVERAGE INFORMATION		
Name of Medicare Beneficiary		Social Security Number
Medicare Number _____	**Type of Coverage** Part A (Hospital) Effective Date_____ Part B (Medical) Effective Date_____	**Medicare Eligibility Due to:** ☐ Age ☐ Disability ☐ End–Stage Renal Disease Initial Dialysis Date:_____
Name of Medicare Beneficiary		Social Security Number
Medicare Number _____	**Type of Coverage** Part A (Hospital) Effective Date_____ Part B (Medical) Effective Date_____	**Medicare Eligibility Due to:** ☐ Age ☐ Disability ☐ End–Stage Renal Disease Initial Dialysis Date:_____