BlueCross BlueShield of Illinois
300 East Randolph Street
Chicago, IL 60601
312.653.6000

IDENTIFICATION NUMBER:

Dear Member:
Your Blue Cross/Blue Shield contract contains a Coordination of Benefits provision. Processing of claims submitted under your contract is dependent upon your response.

PLEASE RESPOND TO THIS QUESTIONNAIRE WITHIN FOURTEEN DAYS

Are you or any member of your family that is currently covered by your Blue Cross and Blue Shield plan also covered by another health or dental insurance policy or Medicare?

_ No If 'No' was checked, please sign and return this questionnaire to us.
_ Yes If 'Yes' was checked, please complete all of the following:

a. Check all that apply:
_ Health _ Dental _ Group Coverage (employment or professional organization) _ Champus
_ Individual policy _ Student policy _ Sport policy _ Medicare Part A and/or Part B _ Other_____

b. Other Insurance Carrier's name: _____
Address:_____
City, State, Zip code:_____ Phone: (____) _____ - _____

c. Other Insurance Policyholder's name: _____ Policyholder's birthdate:_____
Identification or Certificate Number: _____
Effective date: _____ Cancelled date: _____
Policyholder is: _ Actively working _ Inactive _ Retired as of / / _ COBRA as of / /

d. Other Insurance Employer's name:_____
Employers address: _____
City, State, Zip code: _____ Phone (____) _____ - _____

Please complete the following information for all family members covered by other insurance and/or Medicare.
If necessary, use a separate piece of paper to list any additional policies.

Name (First and Last)	Birthdate MMDDYYYY	Social Security # and HIC # (if applicable)	Medicare Effective Date	Reason(s) for Entitlement *	Medicare Cancel Date
Self			Part A Part B		Part A Part B
Spouse			Part A Part B		Part A Part B
Dependant			Part A Part B		Part A Part B
Dependant			Part A Part B		Part A Part B
Dependant			Part A Part B		Part A Part B

The Reason for Medicare Entitlement should be: Attaining age 65, Disability, or End Stage Renal Disease.
Your employer and your Blue Cross and Blue Shield plan appreciate your prompt reply.

Signature: _____ Date: _____

COORDINATION OF BENEFITS UNIT