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 health plan or Medicare?

☐ Yes ☐ No

If yes: — For other health insurance plans, please complete sections 1 & 2.
— For Medicare coverage only, please complete sections 1 & 3.
— For other health insurance plans 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	Birth Date	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	Birth Date	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**	**Medicare Eligibility Due to:**
	Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	☐ Age ☐ Disability ☐ End–Stage Renal Disease Initial Dialysis Date:_____

Name of Medicare Beneficiary	Social Security Number

Medicare Number	**Type of Coverage**	**Medicare Eligibility Due to:**
	Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	☐ Age ☐ Disability ☐ End–Stage Renal Disease Initial Dialysis Date:_____

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HMSA Member Number	Social Security Number	Phone Number

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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				
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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**	**Medicare Eligibility Due to:**
	Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	☐ Age ☐ Disability ☐ End–Stage Renal Disease Initial Dialysis Date:_____

Name of Medicare Beneficiary	Social Security Number

Medicare Number	**Type of Coverage**	**Medicare Eligibility Due to:**
	Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	☐ Age ☐ Disability ☐ End–Stage Renal Disease Initial Dialysis Date:_____

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