Coordination of Benefits Form

UT SELECT
Group No. 71778

Member Name: _____ Social Security No. _____ - ____ - _____
(please print)

Your Blue Cross and Blue Shield contract contains a Coordination of Benefits provision. Processing of claims submitted under your contract are 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
Dependent			Part A Part B		Part A Part B
Dependent			Part A Part B		Part A Part B
Dependent			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: _____

BlueCross BlueShield of Texas

Return completed form to: Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

PRIVACY NOTICE

With a few exceptions, you are entitled to be informed about the information U.T. San Antonio collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review this information. Under Section 559.004 of the Texas Government Code, you are entitled to have U.T. San Antonio correct information about you that is held by us and that is incorrect, in accordance with the procedures set forth in the University of Texas System Business Procedures Memorandum 32. The information that U.T. San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.