

An Independent Licensee of the Blue Cross and Blue Shield Association
1601 West Madison St
Sioux Falls, SD 57104

Member I.D. #
Member Group #
Claim #

Dear

Your contract contains a Coordination of Benefits clause. In order to process your claims, the following current information is required:

While you have been covered by Wellmark, have you or any of your family members been covered by another:

Health Plan Yes No **Dental Plan** Yes No **Prescription Plan** Yes No

If **No**, you must do one of the following:

- Sign, date, and return this form by mail in the enclosed envelope or FAX to 1-515-376-9097.
- Call Customer Service at **1-800-831-4818**.
- **Federal Employees** (ID Numbers beginning with an "R"), call **1-800-532-1537** (Monday through Friday 7:30 am - 5:00 pm).

If you have any questions, please call our Customer Service Department at the phone number on your I.D. card.

If **Yes**, please provide the **required** information below and return this letter by mail in the enclosed envelope or FAX to 1-515-376-9097.

Complete name and address of other insurance company: _____

Other insurance company phone #: _____

Policyholder's name with the other insurance: _____

Policyholder's date of birth with the other insurance: ____/____/____

Identification number with other insurance: _____

Divorce Decrees/Court Orders:

If there are any covered dependents involved in a current or prior divorce situation, does the divorce decree/court order require one parent to provide health insurance coverage for the dependent child(ren)?

Yes - Who is responsible: _____

No - Who has primary physical custody: _____

A copy of the divorce decree/court order is required and will only be used for claims processing. If one has already been provided, you do not need to send in another copy.

If **you** or **any** member of your family are eligible for Medicare, please provide the required information below as it appears exactly on the Medicare card.

Name of eligible person(s): _____ Medicare HIC #: _____

Effective date(s): Part A: ____/____/____ Part B: ____/____/____ Part D: ____/____/____

_____/_____/_____
(Member Signature) _____/_____/_____
(Date)

Federal Employees Only: Warning - Any intentional false statement or willful misrepresentation is a violation of the law punishable by a fine not more than \$10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001).