

# COB Questionnaire

(Please answer all questions completely)

Date Sent:

Subscriber Information	Name of Subscriber:	Member ID #:
Spouse Information	Name of Spouse:	
	Spouse's Place of Employment:	Employer's Address:
	Spouse's Date of Birth:	Spouse's Social Security #:
	Is Spouse covered by any other health insurance?      yes      no	
	<b>If yes, please complete the following:</b>	
	Name of other Insurance Company:	Policy #:
Effective Date of Coverage:		
Dependent Children Information	Are any of your dependent children covered by other health insurance?      yes      no	
	<b>If yes, please complete the following:</b>	
	Name of other Insurance Company:	Policy #:
	Effective Date of Coverage:	Name of Policyholder:
Divorced/ Separated Parents	<b>Please provide the following information:</b>	
	Name of Spouse/Ex-Spouse:	
	Place of Employment:	Employer's Address
	Is Spouse/Ex-Spouse covered by any other health insurance?      yes      no	
	<b>If yes, please complete the following:</b>	
	Name of other Insurance Company:	Policy #:
	Effective Date of Coverage:	
	<i>Please check one:</i>	
<p style="margin-left: 20px;">There is a court order* assigning responsibility for the children's medical expenses to my health care plan.</p> <p style="margin-left: 20px;">There is a court order* assigning responsibility for the children's medical expenses to my Spouse's/Ex-Spouse's health care plan.</p> <p style="margin-left: 20px;">There is no court order assigning responsibility for the children's medical expenses.</p> <p style="margin-left: 20px;">* Please attach a copy of your separation agreement/divorce decree.</p>		
Does Spouse/Ex-Spouse retain custody privileges for any of your dependent children?      yes      no		
If yes, please list names of those dependents:		
Third- Generation Children	Check here if any of your dependent children have become parents themselves.	
	<i>Please complete the following:</i>	
	Name of Newborn:	Name of Newborn's mother:
	Name of Newborn's father:	Father's date of birth:
	Father's place of employment:	Employer's address:
	Is Newborn's Father covered by any other health insurance?      yes      no	
	<b>If yes, please complete the following:</b>	
	Name of other Insurance Company:	Policy #:
Effective Date of Coverage:		
Please Sign and Date	Signature of Subscriber:	Date: