



Horizon Blue Cross Blue Shield of New Jersey

COORDINATION OF BENEFITS QUESTIONNAIRE

Employee Information:

Horizon BCBSNJ ID Number <small>(the number on your ID Card)</small>	Employee Name (Last, First, Middle Initial):	Date of Birth:
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Home Address:

City:	State:	ZIP Code:
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Coordination of Benefits:

1. Is your Spouse or dependent employed? Yes No

2. Is your Spouse or dependent retired? Yes No

3. Does your Spouse/Dependent have other health insurance? Yes No

4. If yes, what is the name and social security number(s) of the person(s) with other Health Insurance _____

5. Please provide the name, address and phone number of other Health Insurance Carrier _____

6. What is the Group Policy ID Number(s) of other Health Insurance Carrier _____

Certification: I hereby certify that the information I have provided on this form is true and accurate. In the event any information is false or misleading, the plan administrator or employer may take appropriate action. In the event benefit payments are incorrectly or improperly made, I shall be fully responsible for repayment to the Plan of all costs, fees and expenses related to such improper or incorrect benefit payment, including a reduction in future payment of claims by the full amount of such improper or incorrect benefit payments.

Employee Signature

Work Telephone

Date

For Assistance Call 1-800-355-2583