USABLE®
MUTUAL INSURANCE COMPANY

Request for Other Coverage Information

For your claims to be processed timely, this Coordination of Benefits (COB) form is required **if you or dependents on your policy** have coverage through another medical health insurance plan.

Please complete and return this form to:

ATTN: COB Department - Exchange
Arkansas Blue Cross Blue Shield
P.O. Box 2181
Little Rock, AR 72203-9974

If you have any questions, please call 1-800-800-4298, Monday - Friday, between 8 a.m. and 5 p.m.

Policyholder Name _____

Policy Number _____

Marital Status

☐ Never Married ☐ Married ☐ Single
☐ Domestic Partner ☐ Separated ☐ Divorced

Section A - Other Medical Health Insurance

Please complete this section if you, your spouse, or dependents have coverage other than this plan.
(Use additional paper if necessary.)

First Name	Last Name	Relationship	Effective Date (mm/dd/yyyy)	Termination Date	Reside in Same Household?
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No
			___/___/_____	___/___/_____	☐ Yes ☐ No

Insurance carrier name _____ **Phone Number** _____

Insurance carrier address _____

Policyholder name _____ **Policy ID#** _____

Date of birth ___ / ___ / _____ **Address** _____
Mo Day Year

Please see reverse side. Signature needed.

Section B - Dependent Children of Separated/Divorced Parents

Please complete this section for any dependent child(ren) listed in Section A whose parents are divorced, legally separated, or who have some other legal reason for providing coverage. (Use additional paper if necessary.)

Dependent First Name	Dependent Last Name	Relationship	Other Insurance Carrier	Policy ID#	Effective Date (mm/dd/yyyy)	Termination Date (mm/dd/yyyy)
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____
					___/___/_____	___/___/_____

Other insurance policyholder name ______________________ **Date of birth** ___ / ___ / _____
Mo Day Year

Other insurance responsible due to

☐ Custody ☐ Divorce Decree ☐ Child Support Order

If any of these boxes are checked, please enclose a copy of the complete document that establishes financial responsibility for medical care.

Section C - Medicare

Please complete this section if you or someone on your policy also has Medicare.

First Name	Last Name	Medicare #		Begin Date	End Date
			Part A	___/___/_____	___/___/_____
			Part B	___/___/_____	___/___/_____
			Reason	☐ 65+ ☐ Disability	☐ ESRD

First Name	Last Name	Medicare #		Begin Date	End Date
			Part A	___/___/_____	___/___/_____
			Part B	___/___/_____	___/___/_____
			Reason	☐ 65+ ☐ Disability	☐ ESRD

First Name	Last Name	Medicare #		Begin Date	End Date
			Part A	___/___/_____	___/___/_____
			Part B	___/___/_____	___/___/_____
			Reason	☐ 65+ ☐ Disability	☐ ESRD

Section D - Signature

I certify that the information provided on this form is true, complete and correct.

Policyholder Signature ______________________ **Date** ___ / ___ / _____
Mo Day Year

☐ I certify that the information provided on this form is true, complete and correct.