

State of Delaware
Department of Human Resources, Statewide Benefits Office

Dependent Coordination of Benefits Form

Section A:

Member Name: _____

Aetna member ID Number or Social Security Number: _____

Do any of your children have other health care coverage?

_____ No...please check this line and sign this form at bottom.

_____ Yes...please complete Section B below and sign this form at bottom.

Section B:

Please complete this section concerning your child/ren's other coverage. If all children have the same coverage, please list each child's name; if children have different coverage, please prepare a separate form for each child.

_____ Child/ren is covered by another Aetna plan and ID Number is _____

_____ Child/ren is covered by another health insurance plan.

Name of the other health insurance plan is _____

Name of policyholder: _____ Birth date _____

Name of employer _____

Effective date of coverage: _____ Date, if cancelled: _____

Names of child/ren covered and birth date:

Child: _____

Child: _____

Child: _____

If divorced, which parent has primary, physical custody? _____ Mother _____ Father

Court Order/ Custody agreement for Dependent Children: Attach Court Order

Individual with primary medical responsibility: _____

Names of child/ren affected by the Court Order/Custody agreement

Child: _____

Child: _____

Child: _____

Thank you for completing this form, your responses will enable claims to be processed properly.

Your signature: _____ Daytime Phone Number: _____

Please print this form, complete, and mail or fax to the following:

Aetna

PO Box 981106

El Paso, TX 79998-1106

Fax# 859-455-8650

You must download this form to your computer and open in Adobe Acrobat to make the fields fillable.