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