PO Box 981610
El Paso, TX 79998

Dear Member:

NCAS is updating information regarding other health insurance coverage for you and your dependents. If you or another family member has other health insurance, including Medicare, please complete this questionnaire in its entirety. If you have NO other insurance, please check NO to question #1. Please return the completed questionnaire to the address listed below. **Failure to return the completed questionnaire may delay processing of claims for you and your dependents.**

1. Are you or your dependents on this policy covered by another health care plan, HMO, dental, or Medicare?
   Yes _____ No _____

If yes, please complete the following. If no, please sign and return the questionnaire.

2. Are you or another member covered by Medicare? Yes_____ No _____
   Please indicate reason for Medicare: Disability ____ End Stage Renal Failure _____ Age _____
   Subscriber Medicare Claim number, including suffix: _____
   Subscriber Medicare Eligibility Dates: Part A_____ Part B _____
   Subscriber's Working Status: Active ____ Retired ____ Date Retired: _____
   Dependent Medicare Claim number, including suffix: _____
   Dependent Medicare Eligibility Date: Part A _____ Part B _____
   Dependent's Working Status: Active ____ Retired ____ Date Retired: _____

3. Name of other Insurance Company: _____
   Address and phone number of other Insurance Company:_____
   _____
   Name of dependent (s) under this policy: _____
   Effective date of policy: _____
   Check off services covered under other plan: Medical ___ Dental ___ Vision ____
   Telephone Number of Other Insurance Company: _____
   Member Name: _____ Policy Number or SS#: _____
   Member date of birth: _____
   Name of Employer providing this coverage: _____

4. Is there a dependent child or children on this policy whose natural parents are separated, divorced or never married? If so, is there a court order placing responsibility for medical insurance? Yes _____No_____

   If yes, please indicate which child (children): _____
   (please attach a copy of court order)
   Please advise who the child(children) lives with:_____

Patient:

_____ _____ ____ _____
Your Signature Date Daytime Telephone #

_____ _____ _____
Name of Member (please print) **Member #** **Group Name**

Please mail this questionnaire back to: NCAS, P.O. Box 981610, El Paso, TX 79998 or fax to 866-281-8554.

Sincerely,

NCAS Claims Department