PO Box 14115
Lexington, KY 40512-4115

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 14115, Lexington, KY 40512-4115 or fax to 866-281-8554.

Sincerely,

NCAS Claims Department