NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN FOR EMPLOYEES AND STAFF

P.O. Box 678, Ashburn, Virginia 20146 ● (703) 729-4677
Fredric V. Rolando, Administrator

IMPORTANT QUESTIONNAIRE RESPONSE REQUIRED

In order to process claims correctly and timely, the Plan must have accurate information. You may refer to Section 9. *Coordinating benefits with Medicare and other coverage* in the Staff Plan brochure. **Please complete this questionnaire for each person on your enrollment; then sign and return the form in the enclosed envelope, addressed to Nongroup Department.**

Name of Member/Dependent: _____ NALC ID#: _____

1. Are you or a covered family member insured with another insurance plan through an employer or through a group organization? Yes _____ No _____

If yes, please complete the following:

Name of Insured: _____ Date of Birth: _____

Relationship to Our Member: Spouse _____ Child _____ Other_____

Name of Employer/Organization: _____ Hire Date: _____

Name of Insurance Plan: _____

Address of Insurance Plan: _____

Telephone Number of Insurance Plan: _____

Policy #: _____ Group #: _____

Effective Date: ____/_____/_____Cancellation Date (if applicable): _____/_____/_____

Does this insurance cover: Hospital ___ Medical ___ Dental ___ Drugs ___ Vision ___

This policy covers: Self Only _____ Self and Spouse _____ Family _____

Insurance is through: Active Employment ___ Retirement ___ Date of Retirement: ___/____/_____

Name of Prescription Drug Plan: _____

Address of Prescription Drug Plan: _____

Phone Number of Prescription Drug Plan: _____

Prescription Drug Plan Policy Number: _____

Effective Date: ____/_____/_____ Cancellation Date (if applicable): _____/_____/_____

Please include a copy (front and back) of the other company's insurance card.

2. Are you or another covered family member receiving treatment for a condition related to an accidental injury? Yes _____ No _____ If yes, please complete the following:
Patient name: _____ Is claim covered by no-fault auto insurance? Yes ___ No ___
What is the condition for which treatment is given? _____
Third party liability (subrogation): Yes ___ No ___ If yes, insurance company's name and address:
_____

3. Are you or a covered family member receiving treatment because of a workplace related illness or injury that has been or will be claimed under OWCP or similar Federal/State Workers' Compensation laws? Yes _____ No _____

If yes, who is receiving treatment? _____

What is the condition for which treatment is given? _____

4. Do you or anyone in your family have Medicare coverage? Yes_____ No _____

If yes, please answer the following questions for each individual:

Name of First Individual: _____ Medicare ID#: _____

Effective Date of Part A (Hospital Insurance): _____/_____/_____

Effective Date of Part B (Medical Insurance): _____/_____/_____

Effective Date of Part D (Prescription Drug Insurance): _____/_____/_____

Do you have a Medicare Advantage policy? Yes _____ No _____

If yes, what is the policy #: _____ Effective Date: ____/_____/_____

Name of Second Individual: _____ Medicare ID#: _____

Effective Date of Part A (Hospital Insurance): _____/_____/_____

Effective Date of Part B (Medical Insurance): _____/_____/_____

Effective Date of Part D (Prescription Drug Insurance): _____/_____/_____

Do you have a Medicare Advantage policy? Yes _____ No _____

If yes, what is the policy #: _____ Effective Date: ____/_____/_____

Please include a copy of the Medicare card for each individual.

To the best of my knowledge, the information provided is true and correct.

Signature: _____ Date: _____

If additional covered family members have other insurance, please provide the information here, or attach another sheet.