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 current brochure. **Please complete this questionnaire for each person on your enrollment and sign.**

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: Self _____ 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.