National Benefit Administrators, Inc.
PO Box 690903, Charlotte, NC 28227-0903
Telephone: 704-844-2966 Fax: 704-844-2977

Employee Name:

SSN or ID#:

Re: Other Insurance

Dear Member,

Your Employer's Health Plan has an annual requirement for collecting updated information pertaining to any other possible health insurance coverage that may be in force for you and/or your covered dependents. In order to avoid any possible delay in claim processing once a claim has been presented to the plan for payment, we are requesting that you provide us with the following information so that we may update your records accordingly. Also, please remember that if any of the information you provide below should change at any point during the year, please notify us immediately.

Do you or your dependents have other health coverage? _____

IF NO, PLEASE SIGN BELOW AND RETURN.
IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION.

- Name of insurance carrier, other than National Benefit Administrators, Inc. _____
- ID Number _____
- Group/Policy Number & Effective Date: _____
- Policy Holder Information:
  *Name of person who is responsible for this policy:
  _____
  *Policy Holder's employer's name and phone number:
  _____
  *Policy Holder's employment status:
  __active or __retired
- Who is covered by this policy?
  _____
  _____
  * Type of benefits provided (check all that apply)
  ___ Medical ___ Vision
  ___ Dental ___ Pharmacy

Employee's Signature:_____ Date:_____

Thank you for your assistance.