27 Corporate Hill Drive
Little Rock AR 72205

IMPORTANT HEALTH INSURANCE INFORMATION – Return within 30 days

Employee Name: _____ **Date of Birth:** _____
(please print)

Address: _____

City, State, Zip Code: _____

Group: Egyptian Area Schools

HealthSCOPE Benefits is requesting up-to-date information regarding any additional health care coverage that you or your covered dependents may have. We must have your reply each year to avoid delays in processing your claims.

1. **If married, is your spouse employed (Yes / No). If Yes, does spouse have coverage where employed? (Yes / No)**
   If no, is coverage available, but simply not elected? **Yes**_____ **No**_____
   If yes, please provide the following:

   Spouse's Employer's Name _____

   Name of Health Plan / Group # / Member # / Eff Date _____

   Are other dependents covered under his/her plan? **Yes**_____ **No**_____

   If yes, please list the covered dependents: _____

2. **Is anyone in your family covered by Medicare?** **Part A: Yes**_____**No**_____ **Part B: Yes**_____ **No**_____

   If yes, who? _____

   What is the Medicare ID number located on your Medicare card? _____

   What date did Medicare become effective? _____

   Reason for Medicare Eligibility? Please circle – Age Disability ESRD Other

3. **Other than identified above, is anyone in your family covered by another plan? Yes**_____ **No**_____
   (Examples: A stepchild covered by a natural parent; a child covered by another parent through divorce decree; an adult dependent covered by his/her own employer, or his or her spouse's employer, or continued coverage for a spouse after termination of employment.) **If yes, provide the following or mark N/A :**

   Dependent Name _____ Relationship_____
   Dependent Name _____ Relationship_____
   Dependent Name _____ Relationship_____

   Name of Health Plan / Group # / Eff Date / Phone # / Policy Holder Name & DOB / Member#
   _____
   _____

   Is there a Divorce Decree or Legal Documentation indicating who is to cover dependent? **Yes**_____ **No**_____
   If yes, please submit a copy along with this completed notice.

Please return to HealthSCOPE Benefits by 09.01.2017: Email: Egyptian.elig@healthscopebenefits.com / Fax: (501) 218-7613 or log into www.healthscopebenefits.com and update your information electronically. **Thank you in advance.**

Signature_____ Date:_____