P.O. Box 12609
El Paso, TX 79912

IMPORTANT HEALTH INSURANCE INFORMATION - PLEASE SEND UPDATE BACK WITHIN 30 DAYS

Name **DATE**
Address
Address

GROUP: **DRURY UNIVERSITY** MEMBER ID: **ALT ID** DEPENDENT: **DEPENDENT NAME**

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, does your spouse have health care coverage where he/she is employed? Yes___ No___**

   If no, is coverage available, but simply not elected? **Yes**___ **No**___

   If your spouse ***is covered*** by their employer, please give their employer name: _____

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

   If yes, please list the dependents covered under his/her plan:

   _____

   _____

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? _____

3. **Other than identified above, is anyone in your family covered by another plan?** (For example, 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.) **Yes**___ **No**___ If yes**,** provide dependent's name(s):

   _____

   _____

4. **Are any of your dependents up to age 26 covered by another group health plan through their employer? Yes**___ **No**___

   If yes, please complete the following:

   Dependent's name(s): 1) _____ 2) _____ 3) _____

   Employer name(s): 1) _____ 2) _____ 3) _____

5. **Are any of your dependents up to age 26 covered by another group health plan through their spouse's employer? Yes___ No**___

   If yes, please complete the following:

   Dependent's name(s): 1) _____ 2) _____ 3) _____

   Spouse's name(s): 1) _____ 2) _____ 3) _____

   Employer name(s): 1) _____ 2) _____ 3) _____

Please return to HealthSCOPE Benefits within 15 days at the following address: HealthSCOPE Benefits - PO Box 12609 – El Paso, TX 79912.
You may also log into www.healthscopebenefits.com and update your information electronically, fax to HSB Eligibility at (915) 581-7537, call Customer Service at (800) 403-1094 or E-Mail this notice to cob.ar@healthscopebenefits.com
Thank you, and we wish you good health.

Signature_____ Date:_____