

IMPORTANT – NEW DRUG PROGRAM INFORMATION

TO ALL PLAN PARTICIPANTS

STARTING JUNE 1, 2000, eligible participants and their dependents will be able to purchase short-term prescription drugs at certain network pharmacies using a plastic I.D. card. To get your I.D. card you must fill out and submit the enclosed Drug Registration Form. **YOU WILL NOT RECEIVE YOUR I.D. CARD IF YOU DO NOT SEND IN THE REGISTRATION FORM, SO PLEASE BE SURE TO DO SO AS SOON AS POSSIBLE.**

Fill out the enclosed Drug Registration Form on the opposite side and mail the completed form to:

Benefit Office – NECA Local No. 145
Attn: Julie Sommers
1700 52nd Avenue, Ste. B
Moline, Illinois 61265

Additional information regarding the new plan will be sent to you along with your I.D. card.

Thank you, in advance, for your prompt attention.

Complete and return immediately to:

Benefit Office – NECA Local No. 145

Attn: Julie Sommers

1700 52nd Avenue, Ste. B

Moline, Illinois 61265

DRUG CARD REGISTRATION FORM

Member's Name _____
(Last) (First) (Middle)

Member's Date of Birth _____ - _____ - _____
(Month) (Day) (Year)

Member's Social Security Number _____ - _____ - _____

Member's Home Address _____
(Street)

(City) (State) (Zip Code)

| Dependent's Name (Last, First, Middle Initial) | Sex M F | Date of Birth Month/Day/Year | |
|---|------------|---------------------------------|--------|
| _____ | ____-____ | ____-____-____ | Spouse |
| _____ | ____-____ | ____-____-____ | Child |
| _____ | ____-____ | ____-____-____ | Child |
| _____ | ____-____ | ____-____-____ | Child |
| _____ | ____-____ | ____-____-____ | Child |
| _____ | ____-____ | ____-____-____ | Child |

Are your dependents covered by any other group health plan: ____ yes ____ no
If yes, complete the section below.

OTHER COVERAGE INFORMATION

- Who does other plan cover? Spouse ____ You and Spouse ____ Family ____
- Plan type: Medicare ____ Medicaid ____ Employer-sponsored ____
- Name and SSN of the insured person (employee/member) _____
- Name of company/group that sponsors the plan _____
- Name and address of company/claims office _____
- If patient is a dependent child and parents are divorced, what is name of parent who has custody of child? _____
- If divorce decree states parent without custody must provide medical coverage for the child, name and address of the parent responsible. _____