

At the request of the Office of Human Resources with The Ohio State University, we are sending this letter to gather information about any other medical plan coverage you and/or your dependent(s) may have. You can expect to receive this request for information from us annually, as coverage situations change and we need to ensure our records are updated accordingly. The coverage information that you provide allows us to properly determine benefit payments under the university's medical plan Coordination of Benefit rules.

Please provide the information listed in the enclosed Request for Additional Coverage Information form to NGS within the next 15 days. This information can be provided to NGS via:

The NGS self-service website at www.ngs.com; or

Phone at: 1-877-647-0083, ext. 83004; or

Fax at: 1-586-226-3111; or

**Mail at: NGS American, Inc.
P.O. Box 2310
Mt. Clemens, MI. 48046**

It is important that you respond to this request, even if you and/or your covered dependents do not have additional coverage, to ensure your claims can be processed in a timely and accurate manner.

If you should have any questions, contact Eligibility Services with NGS American at 1-877-647-0083 EXT. 83004. You may also download this form from the Office of Human Resources web site at <http://hr.osu.edu/forms/ben/ngscob.pdf>

Enclosures

COB004R

Request for Additional Coverage Information

**Please provide the following information for any other medical plan under which you and/or your dependents are covered.
IF NO OTHER COVERAGE EXISTS, PLEASE PROVIDE ONLY ITEMS #1-#3.**

1. OSU Employee's Name: _____
2. NGS Employee's Unique Identifier Number: _____
3. Name of Other Insurance Provider (if none, write "Not Applicable", then sign and date the 2nd page of this form):

4. Other Insurance Provider's Address: _____

5. Policy/Plan Number: _____
6. Effective Date of Other Coverage: _____
7. Names of individual(s) covered by the above plan and also covered by an Ohio State medical plan:

8. Coverage (named in #3) is provided by: (check only one)
 - a. _____ OSU Employee's Previous Employer (COBRA)
 - b. _____ Spouse's Current Employer
 - c. _____ Spouse's Previous Employer (COBRA)
 - d. _____ OSU Employee's Ex-Spouse
 - e. _____ Spouse's Ex-Spouse
 - f. _____ Medicare
 - g. _____ CHAMPUS, Medicaid or other Government Plan
9. Name of Policyholder (for coverage named in #3): _____
10. Policyholder's Social Security Number or Plan Member/ID Number:

11. Policyholder's Date of Birth:

(Continued on the reverse side)

Complete items #12-14 ONLY if you indicated in #8(d) that your dependent child(ren) have medical coverage through a former spouse.

12. Does a divorce decree or child custody agreement establish which parent is responsible for providing medical coverage? YES _____ NO _____

13. If yes, who is the parent responsible for providing primary coverage? _____

14. If no, who has primary custody of the dependent children?

Complete item #15 ONLY if you indicated in #8(f) that other coverage is provided through Medicare.

15. Name of Individual with Medicare Coverage: _____ Eligibility Reason: _____
Age _____
Disability _____
Effective Date of Medicare Coverage: _____ Renal Disease _____

Name of Individual with Medicare Coverage: _____ Eligibility Reason: _____
Age _____
Disability _____
Effective Date of Medicare Coverage: _____ Renal Disease _____

I understand that, as an Ohio State medical plan member, I have the responsibility to provide, when requested, complete and factual information to NGS about any other medical coverage or insurance benefits that I may have, as specified in the Medical Plan Detail Document outlining program provisions for the university's medical plans. I further understand that any person who, knowingly and with intent to defraud, applies for coverage or files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of benefits and/or employment.

I certify that all information provided on this form is true and correct to the best of my knowledge.

Employee's Signature

Date

Thank you for completing this Request for Additional Coverage Information.
Please respond to NGS American using one of the following methods;

The NGS self-service website at www.ngs.com; or

Phone at: 1-877-647-0083, ext. 83004; or

Fax at: 1-586-226-3111; or

**Mail at: NGS American, Inc.
P.O. Box 2310
Mt. Clemens, MI. 48046**