

Use this form to notify NCAS that you are eligible for other group health plan coverage or Medicare.
Please complete the form and send it to NCAS: PO Box 3065, Fairfax, VA 22038

	Participant Notification	
PERSONAL INFORMATION		
Name and mailing address:	Telephone number:	
Identification number:	E-mail address (optional):	
PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one		
I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below. Insert date you became eligible _____	<input type="checkbox"/>	
I am eligible for Medicare. Insert date you became eligible _____	<input type="checkbox"/>	
IMPORTANT		
If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction. Eligibility is determined regardless of whether you take or decline the other coverage. However, eligibility for coverage does not include any time spent in a waiting period.		
To the best of my knowledge and belief all of the answers I have provided on this form are true and correct. Signature _____ Date _____ Type or print name _____		

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list the dependents names here:
