NCBA Benefits Request Form

INSTRUCTION: Please complete and fax to (518) 383-8872

General Member Information

Member Name	____________	**SS #**	____________
Phone	____________	**Best to Call**	____________
Street Address	____________	**D.O.B**	____________
City - State - Zip	____________	**Spouse Name**	____________

Medi-Gap Insurance Plan

___ Member Only ___ Member & Spouse
___ Spouse Only

Payment:
___ Monthly ___ Semiannual
___ Quarterly ___ Annual

Plan Type:
___ Plan A ___ Plan C
___ Plan B ___ Plan F

Current Medicare Booklet? Yes/No

Annuities

Investment Type:
___ Type A ___ Type C
___ Type B ___ Type D
Other: ____________

Payment:
___ Monthly ___ Annual
___ Quarterly ___ Single Payment
___ Semiannual

Payment Amount: $______________

Savings Cards

___ Prescription Card ___ Hearing Card ___ Vision Card

Home Health Care Insurance

___ Member Only ___ Member & Spouse

Payment:
___ Monthly ___ Semiannual
___ Quarterly ___ Annual

Insurance Type:
___ Term Insurance ___ Universal Life
___ Senior Simplified

Amount of Coverage Desired: $ __________

Life Insurance

___ Member Only ___ Member & Spouse

Insurance Type:
___ Term Insurance ___ Universal Life Plan
___ Senior Simplified ___ Whole Life Plan

Payment:
___ Monthly ___ Annual
___ Quarterly
___ Semiannual

Amount of Coverage Desired: $ __________

Long Term Care Insurance

___ Member Only ___ Member & Spouse

Payment:
___ Monthly ___ Semiannual
___ Quarterly ___ Annual

Inflation Protection Yes/No
NY Partnership Plan Yes/No

Daily Nursing Home Benefits __________________
Daily Home Care Benefits __________________
Waiting Period Days ____30 ___ 60 ___ 90 ___ 120 ___ 180

Grandparent/Grandchild Insurance

Name	Date of Birth	Annual Premium Desired