

**MEDICARE QUESTIONNAIRE for DISABLED WIDOW or WIDOWER**

NAME <b>THEODORE PUBLIC</b>	DATE OF BIRTH <b>3/5/1963</b>	MEDICARE NUMBER <b>123456789D</b>
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**INSTRUCTIONS:** This form will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. **USE BLACK OR BLUE INK.**

EXAMPLE 

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**SECTION A - INFORMATION ABOUT YOU**

- 1) Did you remarry after you started receiving Social Security checks?  
YES  NO  (If NO, go to **SECTION B**)
- 2) Are you getting any health coverage from your family member's **current** employment?  
YES  NO  (If NO, go to **SECTION B**)
- 3) How many employees, including your husband/wife, work for your family member's employer?  
Don't Know  100 or more  Less than 100  (If less than 100, **STOP**, go to **Section B**)

Please provide information about the family member, the employer that provides the group health benefits and information about the plan below:

FAMILY MEMBER'S NAME FIRST <b>A M A L I A</b>	Middle Initial	Family Member's Social Security Number <b>9 8 7 - 1 2 - 6 5 4 3</b>
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LAST NAME  
**P U B L I C**

EMPLOYER NAME  
**B R A X T O N I N C**

ADDRESS  
**1 3 5 M A I N S T**

ADDRESS

CITY <b>K A L A M A Z O O</b>	STATE <b>M I</b>	ZIP <b>4 9 0 0 6</b>
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NAME OF GROUP HEALTH PLAN  
**B L U E H O R I Z O N S**

ADDRESS  
**3 9 0 W E S T M A I N S T**

ADDRESS

CITY <b>K A L A M A Z O O</b>	STATE <b>M I</b>	ZIP <b>4 9 0 1 6</b>
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GROUP IDENTIFICATION NUMBER  
**1 2 3**

POLICY NUMBER  
**9 8 7 1 2 6 5 4 3**

**SECTION A - INFORMATION ABOUT YOU AND YOUR FAMILY, CONTINUED**

- 4) Does your family member's employer's group health plan cover prescription drugs? YES  NO   
(If NO, STOP, go to SECTION B)

Please use your family member's insurance card to provide the following information if available:

Rx GROUP

U X P A 5 4 3 2 1

Rx PCN

MEMBER ID

4 5 6 1 2 9 8 7 6

Rx BIN

6 5 4 3 2 1

**SECTION B - MORE INFORMATION ABOUT YOU**

- 1) Are YOU receiving **Black Lung** Benefits? YES  NO   
2) Are YOU receiving Worker's Compensation Benefits? YES  NO   
3) Are YOU receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault, automobile or liability insurance? YES  NO



If you answered YES to any of these questions, go to SECTION C.  
If you answered NO to all of these questions, sign and return only this page.

*Your Signature*  
*Theodore Public*

AREA CODE

5 5 5

PHONE NUMBER

1 2 3

4 5 6 7

MEDICARE QUESTIONNAIRE for DISABLED WIDOW or WIDOWER, CONTINUED

NAME <b>THEODORE PUBLIC</b>	DATE OF BIRTH <b>03/05/1963</b>	MEDICARE NUMBER <b>123456789D</b>
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SECTION C - MORE INFORMATION ABOUT YOU, CONTINUED

1) If **YOU** are getting **Black Lung** (Coal Miner's) Medical Benefits, print the date the benefits began.

M	M	D	D	Y	Y	Y	Y		

2) If **YOU** are now getting any medical services related to an illness or injury which occurred on the job, for which **YOU** have or will file a **Workers' Compensation** claim, print the date of the illness or injury.

M	M	D	D	Y	Y	Y	Y		

Please provide information about the employer, insurance carrier, and attorney in the spaces below:

EMPLOYER NAME

<b>NATIONAL NEWS</b>																			
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ADDRESS

<b>4321 NEWS AVENUE</b>																			
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ADDRESS

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CITY

<b>CINCINNATI</b>																			
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STATE

<b>OH</b>																			
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ZIP

<b>45202</b>																			
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NAME OF INSURANCE CARRIER

<b>CRAZY PEOPLES INSURANCE CO</b>																			
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ADDRESS

<b>1111 STREET ST</b>																			
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ADDRESS

<b>SALTY LAKE BUILDING</b>																			
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CITY

<b>SALT LAKE CITY</b>																			
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STATE

<b>UT</b>																			
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ZIP

<b>84125</b>																			
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POLICY or CLAIM NUMBER

<b>THE054451136</b>																			
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NAME OF ATTORNEY (If Applicable)

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ADDRESS

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ADDRESS

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CITY

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STATE

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ZIP

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BRIEF DESCRIPTION OF ILLNESS OR INJURY

<b>BACK INJURY</b>																			
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**SECTION C - MORE INFORMATION ABOUT YOU, CONTINUED**

3) If **YOU** are now getting any treatment for an illness or injury for which another party could be held liable, please print the date of illness or injury:    -    -

M M D D Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY

STATE

ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY

STATE

ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

4) If **YOU** are now getting any treatment for an illness or injury which could be covered under **no-fault** or **automobile insurance**, print the date of illness or injury:    -    -

M M D D Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY

STATE

ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY

STATE

ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

*Your Signature*  
*Theodore Public*

AREA CODE

PHONE NUMBER

4 3 2 - 1 9 8 - 7 6 5 4

Sample