MEDICARE QUESTIONNAIRE FOR DISABLED BENEFICIARIES NAME DATE OF BIRTH MEDICARE NUMBER MARY SMITH **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. ABC 1 2 3 **EXAMPLE SECTION A - INFORMATION ABOUT YOU** 1) Are you getting any group health coverage from an employer for whom you **now** work (full or part-time)? YES X (If NO, STOP, complete Sections B) NO 2) How many employees, including yourself, work for the employer from whom you get group health benefits? 100 or more Less than 100 (If less than 100, STOP, go to Section B) Don't Know 3) What type of coverage do you have under your employer's group health plan? Worker only coverage Family coverage (husband/wife, other family member) Please provide information about the employer and the employer group health plan in the spaces below: EMPLOYER NAME DYNAMITE CO ACME 345 FARAWAY STREE **ADDRESS** 5|5|5| AVENUE ZIP |6|6|6|6|6 ME **GROUP IDENTIFICATION NUMBER POLICY NUMBER** 4) Does your employer group health plan cover prescription drugs? YES NO (If NO, go to SECTION B) Please use your insurance card to provide the following information if available: Rx GROUP |Z|P|K|X|5|2|1|1| 424424 443322 SECTION B - INFORMATION ABOUT YOUR FAMILY MEMBER 1) On 4/01/2003 , will YOU be receiving any group health coverage through the current employment of a family member? YES X NO (If NO **STOP**, go to **Section C**)

SECTION B - INFORMATION ABOUT	YOUR FAMILY MEMBER, CONTINUED
Family Member's Name	Middle
FIRST	Initial Family Member's Social Security Number
JOHN	J 999-88-7777
LAST S M I T H 	
2) How many employees work for your family member's	s employer?
Don't know 🔀 100 or more 🔲 less than 1	00 [(If less than 100, STOP , go to Section C)
Please provide information about the employer and the emplo	yer group health plan in the spaces below:
EMPLOYER NAME [A C M E D Y N A M 1 T E C O	
ADDRESS	
345 FARAWAY STRE	
CUTY	
SATURN	ME 55555
NAME OF GROUPHEALTH PLAN GOOD HEALHTH INC	
ADDRESS 7 8 9 1 H I R D A V E N U E	
ADDRESS	
SUITE 6	CTATE ZID
MARISIIIII	
GROUP IDENTIFICATION NUMBER	
POLICY NUMBER	
3) Does your family member's employer's group health	plan cover prescription drugs? YES NO
3) Boos your raining member of employer of group neural	(If NO, STOP, go to SECTION C)
Please use your family member's insurance card to pr	_
Rx GROUP Z P R X 5 2 1 1 7 8	Rx PCN
	Rx BIN
MEMBER ID 4 2 4 4 2 4 2	
SECTION C - MORE INF	ORMATION ABOUT YOU
1) Are YOU receiving Black Lung Benefits?	YES NO X
2) Are YOU receiving Worker's Compensation Bend	
3) Are YOU receiving treatment for an injury or illness	
covered under no-fault or auto insurance?	YES NO
If you answered YES to any of these quest If you answered NO to all of these quest	
Your Signature	AREA CODE PHONE NUMBER
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MEDICARE OUESTIONNAIRE FOR DISABLED BENEFICIARIES, CONTINUED DATE OF BIRTH MEDICARE NUMBER MARY SMITH 5/10/54 123456789A SECTION D - MORE INFORMATION ABOUT YOU, CONTINUED 1) If **YOU** are getting **Black Lung** (Coal Miner's) Medical Benefits, print the date the benefits began. D D 2) If YOU are now getting any medical services related to an illness or injury which occured on the job, for which YOU have or will file a Workers' Compensation claim, print the date of the illness or injury. 0 4 - 2 0 - 2 0 0 0 Please provide information about the employer, insurance carrier, and attorney in the spaces below: **EMPLOYER NAME** ACME DYNAMITE CO **ADDRESS** FIAIRIAWAIYI ISITIRIEIEIT 345 **ADDRESS** STATE SATURN 5 5 5 5 5 ME NAME OF INSURANCE CARRIER UNITED HEALTHY PEOPLES INC SOMEWHARE AUE ADDRESS STATE V 01000 101419151514131211101 NAME OF ATTORNEY (If Applicable) MIGUEL CRUZ ESQ **ADDRESS** STREET 125 **ADDRESS** STATE zip | **1** | <u>2 | 3 | 4 | 5</u> |J|A|C|K|S|O|N|V|I|L|L|E| FL BRIEF DESCRIPTION OF ILLNESS OR INJURY

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SECTION D - MORE INFORMATION ABOUT YOU, CONTINUED

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