MEDICARE SECONDARY CLAIM DEVELOPMENT (SCD)

NAME: John Q. Public

MEDICARE HEALTH INSURANCE CLAIM NUMBER: 777-77-7777

PART I - INFORMATION ABOUT YOU

1) Do you have any group health plan coverage based upon your current employment?
YES ☒ **NO** ☐ **(If NO, go to PART II)**

2) How many employees, including yourself, work for the employer from whom you have health insurance?
1-99 ☐ **100 or More** ☒

Please print below the name of the employer and information about the employer group health plan in the spaces below:

EMPLOYER NAME: ABC COMPANY

ADDRESS: 3 TEST DRIVE

CITY: SAMPLE STATE: NY ZIP: 11111

NAME OF HEALTH PLAN: GOOD HEALTH INC.

ADDRESS: 445 37 STREET

ADDRESS: SUITE 100

CITY: TALO STATE: MI ZIP: 11225

DATE INSURANCE COVERAGE BEGAN (M M - D D - Y Y Y Y): 06 - 01 - 1999

POLICY NUMBER: 4362T

TYPE OF INSURANCE: HOSPITAL AND MEDICAL ☐ HOSPITAL ONLY ☐ MEDICAL ONLY ☐

PART II - MORE INFORMATION ABOUT YOU

1) Are you receiving Black Lung Benefits?
YES ☐ **NO** ☒ If **YES,** Date Benefits Began: ___ - ___ - ____ (M M - D D - Y Y Y Y)

2) Are you receiving workers' compensation benefits?
YES ☒ **NO** ☐ If **YES,** Date of Illness or Injury: 01 - 02 - 2002 (M M - D D - Y Y Y Y)

3) Are you receiving treatment for an injury or illness which another party could be held liable or is covered under automobile no-fault insurance?
YES ☐ **NO** ☒ If **YES,** Date of Illness or Injury: ___ - ___ - ____ (M M - D D - Y Y Y Y)

NAME OF INSURANCE CARRIER: GCT WORKERS COMPENSATION

ADDRESS: 21 BROADWAY

ADDRESS:

CITY: NEW YORK STATE: NY ZIP: 11122