

**MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER**

NAME <b>JOHN Q. PUBLIC</b>	DATE OF BIRTH <b>7/23/1935</b>	MEDICARE NUMBER <b>987654321X</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 

A	B	C	1	2	3
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**SECTION A - INFORMATION ABOUT YOU**

- 1) On **7/21/2000**, will YOU be working? YES  NO  (If NO, go to SECTION B)
- 2) Do YOU have any group health plan coverage through your current employer?  
YES  NO  (If NO, go to SECTION B)
- 3) How many employees, including yourself, work for your employer?  
 Don't know  20 or more  Less than 20 (If less than 20, STOP, go to SECTION B)

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME  
**MEGACONGLOMERATE INC.**

ADDRESS  
**123 MAIN STREET**

ADDRESS  
**ASTRA BUILDING**

CITY  
**ANYTOWN** STATE  
**NY** ZIP  
**00000**

NAME OF GROUP HEALTH PLAN  
**ABC INSURANCE CO**

ADDRESS  
**456 FIRST AVE**

ADDRESS

CITY  
**GOTHAM CITY** STATE  
**NY** ZIP  
**99999**

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 **ZPQR52213** Rx PCN

MEMBER ID **597612073** Rx BIN **995544**

**SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE**

- 1) On **3/23/2005**, will you be receiving any group health plan coverage through the current employment of your husband/wife? YES  NO  N/A  (If NO or N/A, STOP, go to SECTION C)

Husband/Wife's First Name \_\_\_\_\_ Husband/Wife's Social Security Number \_\_\_\_\_

Husband/Wife's Middle Initial \_\_\_\_\_ Husband/Wife's Last Name \_\_\_\_\_





**SECTION D - 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*

AREA CODE

PHONE NUMBER

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