MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER MEDICARE NUMBER **NAME** DATE OF BIRTH Q PUBLIC JOHN **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 **SECTION A - INFORMATION ABOUT YOU** 1) On 7/21/2000 , will **YOU** be working? **YES** (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? 20 or more Less than 20 (If less than 20, STOP, go to SECTION B) Don't know Please provide information about the employer and the employer group health plan in the spaces below: EMPLOYER NAME MEGACONGLOMERATE INC |MIA|I|N| |S|T|R|E|E|T ASTRA BUILDING STATE ANYTOWN 00000 NAME OF GROUP HEALTH PLA INSURANCE ABC 4 5 6 IFIIRISIT **ADDRESS** NIY |G|0|T|H|9|M| |C|I| 9 9 9 9 9 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 ZPQR5221 Rx BIN 5 9 7 6 1 2 0 7 3 9 9 5 5 4 4 **SECTION B - INFORMATION ABOUT** YOUR HUSBAND/WIFE On 3/23/2005, will you be receiving any group health plan coverage through the current employment NO X (If **NO** or **N/A**, **STOP**, go to **SECTION C**) of your husband/wife? YES Husband/Wife's Social Security Number Husband/Wife's First Name Husband/Wife's Middle Initial Husband/Wife's Last Name

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MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER, CONTINUED MEDICARE NUMBER DATE OF BIRTH Q PUBLIC 98765432IX 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 M 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. Please provide information about the employer, insurance carrier, and attorney in the spaces below: **EMPLOYER NAME ADDRESS ADDRESS** ZIP **CITY STATE** 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

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: — —														e,																						
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