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MSP (MEDICARE SECONDARY PAYER) SURVEY

This form is required by the Health Care Financing Administration. The answers do not affect your health care coverage in any way!

Name: _____
Address: _____
City, State, Zip: _____

Date: _____
Phone#: _____
Medicare Claim #: _____

Please check the appropriate box:

1. Are you currently working or self-employed? [] Yes [] No
a) If no, insert retirement date and skip to #5. **Retirement Date:** _____
b) If yes, complete #2-4.

2. Does your employer have 20 or more employees? [] Yes [] No

3. Please answer the following questions regarding Insurance coverage through your Employer:
a) Have you refused health coverage through your employer? [] Yes [] No
b) Do you have health coverage through your employer? [] Yes [] No
If yes, please complete the following:
Name of Insurance Company: _____
Policy Number: _____
Effective Date of Coverage: _____
c) Do you have Prescription coverage through your Employer? [] Yes [] No
If yes, please indicate which of the following apply:
[] I have opted-out of the Part-D Prescription Drug Program.

[] I do have Part-D Prescription Drug Coverage through The Health Plan; however, I **DO NOT** have additional prescription through another carrier.

[] I do have Part-D Prescription Drug Coverage through The Health Plan; but I also have additional prescription coverage through the following company:

Continued on next page.....

PLEASE SUPPLY THE INFORMATION ABOUT YOUR OTHER PRESCRIPTION COVERAGE

(most information can be found on your prescription ID card)

<u>Insurance Co. Name & Address</u> _____ _____ _____ Phone No: _____ Bin#: _____ PCN#: _____ (if known)	Subscriber's Name: _____ Group Number: _____ ID Number: _____ Effect Date: _____ Term Date: _____	<u>Employer Information</u> Employer: _____ Address: _____ Actively Emp. [] Retired []
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d) Tell us about your employer:

Company Name: _____
Address: _____
Phone: _____

4. Do you plan to leave your employment or retire in the next:
[] 3 months [] 6 months [] 1 year [] No plans

5. Are you married? [] Yes [] No

a) If no, end of survey. You do not have to complete any more questions.

b) If yes, please complete the remaining questions on this survey.

Spouse's name: _____ Medicare Claim #: _____
(if applicable)

6. Is spouse working or self-employed? [] Yes [] No

a) If no, **insert retirement date and end survey.**

Retirement Date: _____

b) If yes, please complete the remaining questions.

7. Does spouse's employer have 20 or more employees? [] Yes [] No

8. Does spouse have health coverage through his/her employer? [] Yes [] No

Name of Insurance Company: _____

Policy Number: _____

Effective Date of Coverage: _____

9. Does your spouse's health plan include coverage for you? [] Yes [] No

10. Tell us about your spouse's employer:

Company Name: _____

Address: _____

Phone: _____

11. Does your spouse plan to leave his/her employment or retire in the next:

[] 3 months [] 6 months [] 1 year [] No plans

We appreciate you taking the time from your busy schedule to complete this form. Thank you.
COB Department