

Do you or any of your listed dependents have Medicare Parts A and/or B?

Yes No

Name of family member with coverage: _____
Last First M.I.

Medicare No. _____ Effective date Part A _____ / _____ / _____

Effective date Part B _____ / _____ / _____

Are you entitled to Medicare due to ESRD (permanent kidney failure)? Yes No

Is anyone applying for this coverage entitled to benefits from any other group insurance (excluding Medicare, SRS, Medicaid) for surgical, medical or dental expenses? Yes No

Coverage is: Health only Dental only Health and Dental

Name of family member(s) with other coverage _____

Name of employer providing other coverage _____

Address of employer _____

Street

City

State

ZIP

County

Name of insurance company _____

Address of insurance company _____

Street

City

State

ZIP

County

Type of coverage Individual Family ID/Policy No. _____

Signature **X** _____ Date _____ / _____ / _____