MSP (MEDICARE SECONDARY PAYER) SURVEY

The Centers for Medicare & Medicaid Services (CMS) has requested that we report the current working status of our members. So that we can report your status accurately, please complete and return this survey. Your answers will not affect your health care coverage or your membership in the Medicare Advantage plan you have elected. If you have any questions about the survey, please call Member Services toll free at 1.800.624.6961, ext. 7903. TTY members only, call 711. A representative is available to help you from 8:00 am to 8:00 pm, Monday through Friday.

Name: _____ Date:_____

Address: _____ Phone#:_____

City, State, Zip: _____ 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:

PLEASE SUPPLY THE INFORMATION ABOUT YOUR OTHER PRESCRIPTION COVERAGE **(most information can be found on your prescription ID card)**		
Insurance Co. Name & Address	Subscriber's Name:	**Employer Information**
		Employer:
	Group Number:	
	ID Number:	Address:
Phone No.:	Effect Date:	
Bin#:	Term Date:	
PCN#(if known):		Actively Emp. [ ]
		Retired [ ]

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