

Medicare wants to know which **ONE** statement is true for **YOU**:

I am **OVER** 65, married, and:

- 1. My spouse and I are both fully retired. *Medicare is primary for me.*
- 2. I work full or part-time (my spouse is retired) for a company with:
  - a. LESS than 20 employees. *Medicare is primary for me.*
  - b. MORE than 20 employees. *Medicare is secondary for me.*
- 3. My spouse works full or part-time (I am retired) for a company with:
  - a. LESS than 20 employees. *Medicare is primary for me.*
  - b. MORE than 20 employees. *Medicare is secondary for me.*

I am **OVER** 65, not married (includes widowed), and:

- 4. I am fully retired. *Medicare is primary for me.*
- 5. I work full or part-time for a company with:
  - a. LESS than 20 employees. *Medicare is primary for me.*
  - b. MORE than 20 employees. *Medicare is secondary for me.*

I am **UNDER** 65, DISABLED, and:

- 6. I (have / do not have) health care coverage through a Large Group Health Plan with an employer who has 100 or more employees.
- 7. I (have / do not have) health insurance coverage through anyone else.

**Check any Additional Conditions:**

- 8. I have End Stage Renal Disease. *Medicare is secondary for me.*
- 9. I am entitled to Black Lung Benefits. *Medicare is secondary for me.*
- 10. I am entitled to Veteran's Adm. Benefits. *Medicare is secondary for me.*
- 11. COBRA Benefits apply. *Medicare is secondary for me.*
- 12. I was injured in an accident. *Medicare is secondary for me.*

Type of Accident:    • Auto    • Work Related    • Other

Date of Accident: \_\_\_\_\_ Description: \_\_\_\_\_

- 13. I was treated by a home healthcare agency. Date of last home treatment: \_\_\_\_\_

**If none of the above describes your situation, please explain:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Beneficiary/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Beneficiary/Patient