LABORERS'
BENEFITS • ST. LOUIS

Medicare Coverage Questionnaire

Member Name: _____ ID or S.S. #: _____

Address: _____ Phone #: _____

Are you receiving a check from Social Security? ○ Yes ○ No

Have you been awarded a Social Security Disability? ○ Yes ○ No If yes, when_____

Do you currently have Medicare coverage? ○ Yes ○ No

If yes, please complete the following information and submit a copy of both sides of your Medicare card.

When did you become eligible for Medicare coverage?

Medicare A _____ Medicare B _____

Spouse/Dependent Name: _____ ID or S.S. #: _____

Address: _____ Phone #: _____

Are you receiving a check from Social Security? ○ Yes ○ No

Have you been awarded a Social Security Disability? ○ Yes ○ No If yes, when_____

Do you currently have Medicare coverage? ○ Yes ○ No

If yes, please complete the following information and submit a copy of both sides of your Medicare card.

When did you become eligible for Medicare coverage?

Medicare A _____ Medicare B _____

I understand that it is my responsibility to immediately notify the Benefit Office of any changes in the above information. I certify the above statements are true, complete and accurate to the best of my knowledge. I understand if anything is untruthful, it could result in my termination and/or termination of my dependents and recoupment by the plan. I authorize any physician, hospital, employer, insurance company, or other informant to furnish any information necessary to consider claims(s) on dependents and myself listed above. A photocopy of this authorization should be as valid as the original.

Member Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

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