MA Plan Questionnaire

Name: _____

Date of Birth: _____ Social Security Number: _____

1) At the present time are you (the member) or your spouse working?
_____ Yes _____ No

If yes, name of working person(s) _____

If not working, please supply the date that you and/or your spouse ceased working (i.e. date of retirement or date of employment termination).
_____ You _____/_____/_____ Date of Retirement/Date of Employment Termination
_____ Spouse _____/_____/_____ Date of Retirement/Date of Employment Termination

2) Do you or your spouse have group health plan coverage through an employer?
_____ Yes _____ No

3) How many employees work for the employer that offers the group health plan coverage?
_____ 1-19 employees _____ 20-99 employees _____100 or more employees

4) Please supply the name and address of the employer that offers the group health plan coverage.

_____

_____

_____

5) Please supply the name and address of the group health plan, i.e., the insurance company.

_____

_____

_____

6) Do you have group health plan coverage through a family member other than your spouse?
_____ Yes _____ No If yes, what is the relationship? _____

(**If the response to question 6 is No, STOP.** If the response is yes, continue to question 7).

7) Is the family member from the previous question currently employed?
_____ Yes _____ No

8) How many employees does the family member's employer have?
_____ 1-99 employees _____ 100 or more employees

9) Please supply the name and address of the family member's employer.

_____

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10) Please supply the name and address of the group health plan, i.e., the insurance company.

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