Annual Medicare Questionnaire

Please complete this form annually and return to your benefits administrator by January 1st. You will also need to notify CTSI if there are any changes through out the year.

Name: _____

Social Security Number: _____

Date of Birth: _____

I/my spouse are currently employed with: _____

Date Eligible for Medicare: _____

I am Enrolled in:

☐ Part A Effective Date: _____

☐ Part B Effective Date: _____

☐ Part D Effective Date:_____

Medicare #:_____

I am on Medicare due to a disability:

Yes ☐ No ☐

I am on Medicare due to End Stage Renal Disease:

Yes ☐ No ☐

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