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MEDICARE ELIGIBILITY FORM

Group Number:	Group Name:
Subscriber ID Number:	Member Name:
CHECK ONE STATEMENT THAT REPRESENTS YOUR TOTAL EMPLOYEE POPULATION: ☐ Employs 20 or less ☐ Employs 20 or more ☐ Employs 100 or more	If Member does not have Medicare please indicate reason for not having Medicare:
☐ A. Active Employee	Medicare Beneficiary Identifier (MBI) _____ Social Security Number _____ Medicare Part A Effective Date _____ Medicare Part B Effective Date _____
☐ B. Dependent of Actively Working Employee	Medicare Beneficiary Identifier (MBI) _____ Social Security Number _____ Medicare Part A Effective Date _____ Medicare Part B Effective Date _____
☐ C. Retired Employee Retirement Date _____	Medicare Beneficiary Identifier (MBI) _____ Social Security Number _____ Medicare Part A Effective Date _____ Medicare Part B Effective Date _____
☐ D. Dependent of Retired Employee Subscriber Retirement Date _____	Medicare Beneficiary Identifier (MBI) _____ Social Security Number _____ Medicare Part A Effective Date _____ Medicare Part B Effective Date _____
☐ E. Disabled Employee/Dependent	Medicare Beneficiary Identifier (MBI) _____ Social Security Number _____ Medicare Part A Effective Date _____ Medicare Part B Effective Date _____
☐ F. End Stage Renal Disabled Employee/Dependent Date of First Dialysis _____ Type of Dialysis (Check One): ☐ Self ☐ Facilitated Date Transplant Received (if applicable): / /	Medicare Beneficiary Identifier (MBI) _____ Social Security Number _____ Medicare Part A Effective Date _____ Medicare Part B Effective Date _____

Mail completed form to: PO Box 21146, Eagan, MN 55121-0146

Group Representative Signature: _____ **Date:** _____

Member Signature: _____ **Date:** _____