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 throughout 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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