



CITY OF WORCESTER MEDICARE HEALTH INSURANCE INFORMATION

Part 1: To be completed by Applicant

Name	Date of Birth
Street Address	City State Zip
Social Security Number	Spouse's Name
Spouse's Date of Birth	Spouse's Social Security Number
Applicant's Signature Date	Home Telephone Number

Part 2: To be completed by Social Security Administration (check all that apply)

APPLICANT'S MEDICARE CLAIM NUMBER: _ _ _ - _ _ - _ _ _ _ _

The above named beneficiary is entitled to Premium Free Medicare Hospital Insurance (Part A).

Part A Effective: Mo/Yr _____

The above named beneficiary is not entitled to Premium Free Medicare Hospital Insurance because he/she has not paid into Social Security (or MQGE) for the required number of quarters and his/her spouse, Age 62 or older, has not paid into Social Security (or MQGE) for the required number of quarters.

The above named beneficiary states he/she has health insurance through an Employer Group Health Plan as an active employee (or covered as a spouse of an active employee) and therefore has declined enrollment in Part B.

The above named beneficiary is enrolled in Medicare Medical Insurance (Part B).

Part B Effective: Mo/Yr _____

Social Security District Office Address: _____

Signature of SSA Official: _____ Date: _____

Printed Name of SSA Official: _____