CITY OF WORCESTER
MEDICARE HEALTH INSURANCE INFORMATION

TO BE COMPLETED BY APPLICANT WHEN FILING AN APPLICATION WITH SOCIAL SECURITY

_____ _____ _____
Beneficiary's Name | Date of Birth | Social Security Number

_____ _____
Street Address | City State Zip

SPOUSE'S INFORMATION

_____ _____ _____
Spouse's Name | Date of Birth | Social Security Number

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

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

____ The above named beneficiary filed an application with Social Security.

____ 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: _____ (Rev. 03/2011)

Print Form