



# Medicare Working Aged Survey

FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C  
ADDRESS-1  
ADDRESS-2  
CITY; STATE; ZIP

Please complete and return  
this survey by:

SYSDATEA

Dear Member:

The Centers for Medicare and Medicaid Services, the federal agency that administers Medicare, requires us to verify and update our records. Please answer the following questions about yourself, your spouse, and your health care coverage. The information you provide will remain **confidential** and will not affect your Medicare coverage or your membership with Preferred Care.

If both you and your spouse receive a copy of this questionnaire, please complete and return both questionnaires.

Please return your completed survey within 14 days using the enclosed postage-paid envelope. If you are not able to complete this survey by yourself, please have a family member or caregiver assist you.

If you have any questions about the survey, please call Member Services at (585) 327-2480 or (800) 665-7924. For TTY/TDD access call (585) 325-2629 or (800) 662-1220.

Sincerely,

Jane Gentile  
Director of Operations

#### Statement of Confidentiality

Preferred Care respects your right to privacy. Your responses to this survey will not be shared with anyone without your prior consent. All the information that would let someone identify you or your family will be kept private. The information you provide will remain confidential and will not affect your Medicare coverage or your membership with Preferred Care.

Please return the questionnaire in the envelope provided to:

Other Party Liability Department | Preferred Care | 259 Monroe Avenue | Rochester, NY 14607

# 1. INFORMATION ABOUT YOU

## YOUR EMPLOYMENT STATUS

1. Are you retired now, or not?

- <sub>1</sub> Retired  
<sub>2</sub> Not retired

2. Which of the following best describes your current employment status? **(CHECK ONLY ONE)**

- <sub>1</sub> Working full-time  
<sub>2</sub> Working part-time  
<sub>3</sub> Not working → **GO TO QUESTION 6**

## ABOUT YOUR EMPLOYMENT

3. Does your employer have 20 or more employees?

- <sub>1</sub> Yes  
<sub>2</sub> No

4. Do you have health care insurance through your current employer?

- <sub>1</sub> Yes → **GO TO QUESTION 5**  
<sub>2</sub> No → **GO TO QUESTION 6**

5. Please provide the following information about your employer and insurance coverage:

Employer Name

Employer Phone Number

Health Insurance Company Name

Health Insurance Policy / Contract Number

When Health Insurance Started (Month / Year)

Which of the following services does your health insurance cover?

- Hospital**  
 **Dental**  
 **Pharmacy**  
 **Vision**  
 **Medical / Office Visits**

For pharmacy coverage, please use your pharmacy insurance card to provide the following information:

- Rx Group: \_\_\_\_\_  
 Rx PCN: \_\_\_\_\_  
 Rx BIN: \_\_\_\_\_  
 Member ID: \_\_\_\_\_

## MARITAL STATUS

6. Are you married? **(CHECK ONLY ONE)**

- <sub>1</sub> Yes, married → **GO TO QUESTION 7**  
<sub>2</sub> No, not married } **GO TO QUESTION 14**  
<sub>3</sub> Widowed }

## 2. INFORMATION ABOUT YOUR SPOUSE

### YOUR SPOUSE'S EMPLOYMENT STATUS

7. Is your spouse retired now, or not?

- <sub>1</sub> Retired  
<sub>2</sub> Not retired

8. Which of the following best describes your spouse's current employment status?

**(CHECK ONLY ONE)**

- <sub>1</sub> Working full-time  
<sub>2</sub> Working part-time  
<sub>3</sub> Not working → **GO TO QUESTION 14**

9. Does your spouse have health care insurance through his/her current employer?

- <sub>1</sub> Yes → **CONTINUE**  
<sub>2</sub> No → **GO TO QUESTION 14**

10. Does your spouse's health insurance policy include coverage for you?

- <sub>1</sub> Yes → **CONTINUE**  
<sub>2</sub> No → **GO TO QUESTION 14**

11. Please provide your spouse's name and social security number:

Spouse's Name

Spouse's Social Security Number (SSN)

### ABOUT YOUR SPOUSE'S EMPLOYMENT

12. Does your spouse's employer have 20 or more employees?

- <sub>1</sub> Yes  
<sub>2</sub> No

13. Please provide the following information about your spouse's employer and insurance coverage:

Spouse's Employer Name

Spouse's Employer Phone Number

Spouse's Health Insurance Company Name

Spouse's Insurance Policy / Contract Number

When Spouse's Insurance Started (Month / Year)

**CONTINUE** 

### 3. OTHER INSURANCE COVERAGE

14. Did you ever have an **automobile accident** for which you received health or medical care?

<sub>1</sub> Yes

<sub>2</sub> No → **GO TO QUESTION 16**

15. Please provide the following information about insurance coverage you are receiving due to an automobile accident.

Type of Injury	
Date of Injury	Claim / Case Number
Insurance Company Name	Insurance Company Address

16. Did you ever have an **accident or injury at work** for which you received health or medical care?

<sub>1</sub> Yes

<sub>2</sub> No → **GO TO QUESTION 18**

17. Please provide the following information about insurance coverage you are receiving due to a work accident.

Type of Injury	
Date of Injury	Claim / Case Number
Insurance Company Name	Insurance Company Address

18. Did you ever have an **accident or injury at a public location** for which you received health or medical care?

<sub>1</sub> Yes

<sub>2</sub> No → **END OF SURVEY. THANK YOU.**

19. Please provide the following information about insurance coverage you are receiving due to an accident you sustained.

Type of Injury	
Date of Injury	Claim / Case Number
Insurance Company Name	Insurance Company Address