Working Aged Survey

The Centers for Medicare & Medicaid Services (CMS) has requested that we report the current working status of our members. So that we can report your status accurately, please complete this survey. This survey will not affect your Medicare coverage or your membership in the Medicare Advantage plan you have elected. Please check the appropriate boxes.

Name *(please print)*:________________________________ **Medicare Number:**________________________

Address: ____________________________________ **City:**__________________ **State:** ____ **Zip code:**________

1. Are you currently working and/or self employed?
   ☐ Yes (Go to Question 3.) ☐ No
2. What is your current status?
   ☐ Retired – When? Month ___ Year____ (Go to Question 9.)
   ☐ Never worked outside the home, or disabled (Go to Question 9.)
3. Before your current position, did you retire from another company?
   ☐ Yes – When? Month ____ Year____ ☐ No
4. Do you currently have health coverage in addition to your Medicare Advantage through your current employer?
   ☐ Yes ☐ No (Go to Question 9.)
5. How many employees does your current employer have?
   __________ Employees
6. Please fill in the insurance and employer information below.
   ***Note:* This information will be used only for coordination of benefits.**
   Insurance company ______________________________
   Policy number ______________________________
   Effective date of coverage ________________
   Employer name ______________________________
   Employer address ______________________________
   Employer city ________________ State ____ Zip _______
   Employer phone number ______________________________
7. What is your planned date of retirement?
   Month ______ Year______ ☐ Don't know
8. Do you plan to continue your employer health coverage?
   ☐ Yes ☐ No – When will/did the coverage end?
   Month ______ Year______
9. Are you married? ☐ Yes ☐ No (Survey is complete.)
10. **Spouse's name** ______________________________
    Social Security number ______________________________
11. Is your spouse currently working and/or self employed?
    ☐ Yes (Go to Question 13.) ☐ No
12. What is your spouse's current status?
    ☐ Retired – When? Month ____ Year____ (Survey is complete.)
    ☐ Never worked outside the home, or disabled (Survey is complete.)
13. Before your spouse's current position, did your spouse retire from another company?
    ☐ Yes – When? Month ____ Year____ ☐ No
14. Does your spouse have health coverage through his/her current employer?
    ☐ Yes ☐ No (Survey is complete.)
15. Does your spouse's health plan include coverage for you?
    ☐ Yes ☐ No (Survey is complete.)
16. How many employees does your spouse's employer have?
    __________ Employees
17. Please fill in the insurance and employer information below.
    ***Note:* This information will be used only for coordination of benefits.**
    Spouse's insurance company ______________________
    Spouse's policy number ______________________
    Effective date of coverage ________________
    Spouse's employer name ______________________
    Spouse's employer address ______________________
    Spouse's employer city _____________ State ___ Zip ______
    Spouse's employer phone number ______________________
18. What is your spouse's planned date of retirement?
    Month ______ Year______ ☐ Don't know
19. Has your spouse continued to carry health coverage for you beyond your Medicare Advantage coverage effective date?
    ☐ Yes ☐ No – When will the coverage end?
    Month ______ Year______

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Note to Applicants: Be sure to complete this survey and return the original with your completed enrollment form.

Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al numero telefónico que se muestra en el material adjunto.
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White copy - Return to Anthem **Yellow copy** - For Applicant/Member **Pink copy** - For Agent/Broker

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