

# 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 \_\_\_\_

2006-223-MA 03/2006

**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. M0013\_08\_014 07/2007

White copy - Return to UniCare

Yellow copy - For Applicant/Member

Pink copy - For Agent/Broker

Coverage provided by UniCare Life and Health Insurance Company. ®Registered mark and ™ service mark of WellPoint, Inc.