

IMPORTANT NOTICE FOR MEDICARE SAVINGS PROGRAM RECIPIENTS

If you want the State of North Carolina to continue paying your Medicare Part B premium, you must complete and sign this application and return it to the County Department of Social Services by

_____ fold here _____

REENROLLMENT APPLICATION FOR QUALIFYING INDIVIDUALS

Read these instructions first. Fill out the front and back of this application completely. Read the inserted Rights and Responsibilities thoroughly. **Sign your name** on the back of the application and return it in the enclosed envelope. Fold it so the county's address shows through the window. Include any other information requested below with the application. **Put a stamp on the envelope.** If you have any questions or need help completing the application, call the DSS office phone number above.

If you are acting on behalf of the recipient, please answer all questions for that person and sign your name and relationship to the recipient at the end of the form.

1. What is your current address? _____
2. Telephone number or number where you can be reached _____
3. Do you live with your spouse? _____
If yes, spouse's name _____

(If your spouse wants to apply for Medicaid or Medicare Savings Programs, he/she must complete his own application.)

4. INCOME -- Do you or your spouse have any of the following income?

TYPE OF INCOME	GROSS AMOUNT	HOW OFTEN RECEIVED	WHO RECEIVES IT
Your Social Security			
Spouse's Social Security			
Your Retirement/Pension			
Spouse's Retirement/Pension			
Veteran Benefit			
Rental Income			
Earned income			
Contributions			
Other income			

Include a copy of your most recent award letters, pay stubs, or other verification of your income in the same envelope.

5. ASSETS -- Do you or your spouse have any of the following assets?

TYPE OF ASSET	Account Number	Name of Bank or Insurance Co., or location of property	Cash or Tax Value	Amount Owed
Cash on hand				
Checking Account(s)				
Saving Account(s)				
Land/buildings (other than homesite)				
List vehicles (cars, boats, trucks, recreational, motorcycle, etc.)				
List Life Insurance policies				
List any other asset you or your spouse own and its value				

PLEASE INCLUDE YOUR MOST RECENT BANK STATEMENT FOR ALL ACCOUNTS IN THE SAME ENVELOPE.

6. If you have a medical or health insurance policy, write the name of the company and account number:

READ, SIGN, AND DATE HERE

I, the undersigned authorize the release of any information necessary to establish Medicaid eligibility. I understand this information may include medical or non-medical information, including such collateral sources as banks, employers, and insurance companies. This authorization may be reproduced.

I certify I have read the enclosed Rights and Responsibilities.

X _____
Signature Date signed

X _____
Representative/witness Relationship to client Date signed