

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) balance as of 9/30 | | | | |
| Saving Account(s) balance as of 9/30 | | | | |
| 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 SEPTEMBER 30 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