MEDICARE SUPPLEMENT INDIVIDUAL ENROLLMENT FORM
_____SPONSORED GROUP PLAN

Desired Effective Date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	Mr. Mrs. Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	Social Security Number:	Home Phone Number: ( )
Permanent Residence Street Address:			
City:	State:	ZIP Code:	

Mailing Address (only if different from your Permanent Residence Address):
Street Address: City: State: ZIP Code:

Emergency Contact: [Optional]

Phone Number: [Optional]_____ **Relationship to You** [Optional] _____

E-mail Address: [Optional]

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: _____

Medicare Number
__ __ __ __ - __ __ __ - __ __ __ __

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Signature: _____ Today's Date:_____