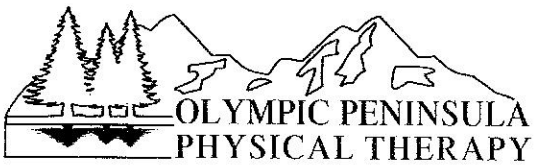

DATE: _____

Medicare patients please complete the following questionnaire.

Part I
Are you receiving Black Lung Benefits?
_____ Yes
_____ No

Part II
Was the illness/injury due to a work-related accident?
_____ Yes
_____ No

Part III
Was illness/injury due to a non-work related accident, such as a Motor Vehicle Accident?
_____ Yes
_____ No

Part IV
Are you entitled to Medicare based on:
_____ Age > **Go to Part V**
_____ Disability > **Go to Part V**
_____ End Stage Renal Disease > **Go to Part V**

Part V
Are you currently employed?
_____ Yes
_____ No If appropriate, date of retirement _____ (Month/Year)
_____ No Never employed

Do you have a spouse who is currently employed?
_____ Yes
_____ No If appropriate, date of retirement _____ (Month/Year)
_____ No Never employed

Part VI
Do you have group health plan coverage? **(OTHER THAN MEDICARE OR SECONDARY POLICY)**
_____ Yes
_____ No

Signature_____ **Please print Name** _____

If you answered NO to all questions, Medicare is your primary insurance.
If you answered YES to any questions, you will asked to complete an additional form.
Thank you for your cooperation.