univera HEALTHCARE
PO Box 211256
Eagan, MN 55121-2656
UniveraHealthcare.com

MEDICARE ELIGIBILITY FORM

Group Number:	**Group Name:**
Subscriber ID Number:	**Member Name:**
CHECK ONE STATEMENT THAT REPRESENTS YOUR TOTAL EMPLOYEE POPULATION: **_____Employs 20 or less** **_____Employs 20 or more** **_____Employs 100 or more**	**If Member does not have Medicare please indicate reason for not having Medicare:** **_____**
___A. Active Employee	**Medicare Beneficiary Identifier (MBI) _____** **Social Security Number _____** **Medicare Part A Effective Date _____** **Medicare Part B Effective Date _____**
___B. Dependent of Actively Working Employee	**Medicare Beneficiary Identifier (MBI) _____** **Social Security Number _____** **Medicare Part A Effective Date _____** **Medicare Part B Effective Date _____**
___C. Retired Employee **Retirement Date** **_____**	**Medicare Beneficiary Identifier (MBI) _____** **Social Security Number _____** **Medicare Part A Effective Date _____** **Medicare Part B Effective Date _____**
___D. Dependent of Retired Employee **Subscriber Retirement Date** **_____**	**Medicare Beneficiary Identifier (MBI) _____** **Social Security Number _____** **Medicare Part A Effective Date _____** **Medicare Part B Effective Date _____**
___E. Disabled Employee/Dependent	**Medicare Beneficiary Identifier (MBI) _____** **Social Security Number _____** **Medicare Part A Effective Date _____** **Medicare Part B Effective Date _____**
___F. End Stage Renal Disabled Employee/Dependent **Date of First Dialysis_____** **Type of Dialysis (Check One):** **Self_____ Facilitated _____** **Date Transplant Received (if applicable):** **_____/_____/_____**	**Medicare Beneficiary Identifier (MBI) _____** **Social Security Number _____** **Medicare Part A Effective Date _____** **Medicare Part B Effective Date _____**

Mail completed form to: PO Box 211256, Eagan, MN 55121-2656

Group Representative Signature: _____Date: _____

Member Signature: _____Date: _____