MEDICARE SUPPLEMENTAL FORM

Name: _____ Date: _____

Are you 65 years of age or older? **Yes** **No**
Have you fallen in the last year? **Yes** **No**
If yes, how many times? _____
If yes, were you injured during the fall? **Yes** **No**
If you were injured in the fall, please explain what happened. _____
_____

1. Yes **No** Have you had any home health care in the past 60 days?
If yes, please provide the name and phone number of the agency.
Name of agency: _____ Phone number _____

2. Yes **No** Are you entitled to benefits under the Black Lung Program, Department of Veteran Affairs or any other government agency?
This government program is to be primary to Medicare. If yes:

Program name: _____
Address: _____
City, State and Zip Code: _____

3. Was your illness/ injury due to any of the following:
Yes **No** Work Related Accident Date: _____
Yes **No** Automobile Accident Accident Date: _____
Yes **No** Accident on another's property Accident Date: _____
(example: store, restaurant, etc.)

Please provide the following contact information for liability insurance.
Insurance name: _____ Contact: _____
Address: _____
City, State, and Zip: _____ Phone Number: _____

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