



[Date]

«First_Name» «Last_Name»
«Address1» «Address2»
«City», «State» «ZIP»

Member ID: «MemberID»

Dear «First_Name» «Last_Name»,

The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, requires us to verify and update our records. Please answer the following questions about yourself, your spouse, and your current address. Information from the survey will not affect your Medicare coverage or your membership with your health plan.

If both you and your spouse receive a copy of this questionnaire, please complete and return both questionnaires. Enclosed is a postage-paid envelope.

Please complete the questions and return them to us as soon as possible. If you have any questions regarding this survey, please contact Touchstone Health Member Concierge at 1-888-777-0204, TTY: 1-877-867-5814, Monday through Friday, 8:00 AM to 8:00 PM.

Cordially,

Touchstone Health
Enrollment Department

Y0064_H3327_THPSMK_1452 File & Use 09172011

Touchstone Health HMO, Inc. is a Medicare-approved Health Maintenance Organization with a Medicare Advantage Prescription Drug contract with the federal government.

CMS Working Aged Survey

Date: _____

Name: _____ Phone: _____

Address: _____

City, State, Zip: _____ Medicare ID# _____

1. Are you working or self-employed? YES NO
(If no, go to #1 on next page)

2. Does your employer have 20 or more employees? YES NO
(If no, go to #1 on next page)

3. Tell us about your employer.
Company: _____
Address: _____
Phone: (____) _____

4. Do you plan to leave your employment or retire in the next?
 3 months 6 months 1 year No plans

Retirement date: _____

5. Do you have health insurance through your employer? YES NO
(If no, go to #1 on next page)

6. When did this employer insurance coverage start? Month/Year _____
Tell us about your Insurance:

Company: _____
Address: _____
Phone: (____) _____

7. Does your insurance include prescription drug coverage? YES No
If yes, please provide the following information from your ID card

RX ID# _____ RX GROUP # _____

RX PCN# _____ RX BIN# _____

8. Has this insurance coverage ended? If so, when? YES Month/Year: _____
 NO

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SPOUSE
CMS Working Aged Survey

1. Are you married? YES NO
(If no, end of survey.) (If yes, complete the following.)
- 1a. Spouse's name: _____
2. Is your spouse working or self-employed? YES NO
(If no, skip to #5 and complete the retirement date)
3. Does your spouse's employer have 20 or more employees? YES NO
4. Does your spouse plan to leave employment? YES NO
Plans to leave in: 3 months 6 months 1 year
5. Retirement date: (Past or future month/year) _____
6. Does your spouse have health insurance through an employer? YES NO
7. When did this employer insurance coverage start? Month/Year _____ Tell us
about your Insurance:
Company: _____
Address: _____
Phone: (____) _____
8. Does your spouse's insurance include prescription drug coverage? YES NO
If yes, please provide the following information from your ID card
RX ID# _____ RX GROUP # _____
RX PCN# _____ RX BIN# _____
9. Has this insurance coverage ended? If so, when. YES Month/Year: _____
 NO
10. Does your spouse's employer insurance coverage include coverage for you?
 YES NO

PLEASE INCLUDE THIS SURVEY IN THE ENCLOSED SELF ADDRESSED PRE-PAID ENVELOPE. THANK YOU.

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