VIVA MEDICARE PLUS
SURVEY OF OTHER INSURANCE

Medicare requires Viva Medicare *Plus* to survey each member every year about other insurance. Please fill out and return your survey in the envelope provided. Call Member Services at (205) 918-2067 or 1-800-633-1542 if you have questions. TTY users call 1-800-548-2546. Office hours are Monday-Friday, 8am to 8pm. If both you and your spouse are members, you must each complete a separate survey.

Your Name (Print): _____

1. Do you or your spouse currently work for an employer with 20 or more employees AND do you get health insurance from that employer? (If you or your spouse retired from that employer check "NO.")

NO ☐ **YES** ☐ **If you checked yes, complete section A below.**

2. Do you have any other prescription drug insurance or coverage (not including drug discount cards) besides Viva Medicare *Plus* Rx?

NO ☐ **YES** ☐ **If you checked yes, complete section B below.**

If you checked "NO" to both questions 1 and 2 above, YOU ARE DONE. Please sign here and return the survey in the envelope we gave you.

SIGN YOUR NAME HERE: _____

Section A. Complete this section only if you checked "YES" to question 1.
How many employees work for the employer?

Don't know ☐ 1-19 ☐ 20-99 ☐ 100 or more ☐

Employer name: _____

Employer address: _____

_____

_____

Is the company listed above your employer or your spouse's employer? (Circle one)

My current employer My spouse's current employer

TURN PAGE OVER

Only if you circled "My spouse's current employer" complete "a" and "b" below.

a. Spouse's Name: _____

b. Spouse's Medicare or Social Security Number: _____

Name of Insurance Company: _____

Group Number: _____ Policy Number: _____

Date this other cover began (monthly/day/year): _____ / _____ / _____

Does this insurance plan include prescription drug insurance? _____ YES _____ NO

Section B. Complete this secion only if you checked "YES" to question 2. If you answers "NO" to question 2 you are done. Sign below and return.

What kind of prescription drug insurance do you currently have **OTHER THAN** the Viva Medicare Plus Rx prescription drug benefit (discount cards do not count)?

_____ A health plan from an employer (Employer: _____)
_____ Are you retired from this employer? _____YES _____NO
_____ A Medicare supplement or Medigap plan
_____ Veteran's Administration
_____ TRICARE
_____ Black lung (coal miner's) benefits
_____ Workers compensation (Employer: _____)
_____ Insurance benefits from an injury or illness (such as an auto accident)
_____ Other. Describe: _____

Provide the information below about your other prescription drug insurance. This information is probably on your health insurance or prescription ID card.

Insurance Carrier Name: _____

Insurance Carrier Address: _____

_____

_____

Group number: _____ Policy Number: _____
Date coverage began: _____ / _____ / _____ Member #: _____
Rx Group _____ Rx PCN _____ Rx BIN _____

SIGN YOUR NAME HERE: _____

Telephone number: ( ) _____