



APPLICATION

PLEASE PRINT CLEARLY

FILL OUT
 THIS FORM
 COMPLETELY.

ENTER THE
 ADDRESS THAT
 WE SHOULD
 USE WHEN WE
 SEND YOU
 INFORMATION.

REMEMBER:
 • YOU MUST BE
 65 OR OLDER
 TO ENROLL.
 • YOU MUST
 SEND PROOF
 OF AGE
 WITH YOUR
 APPLICATION.

Who is applying? <input type="checkbox"/> Yourself only <u>or</u> <input type="checkbox"/> Yourself and your spouse			
Your Last Name	First	Middle Initial	Social Security Number
c/o Name (if different from above)			Your Date of Birth
Mailing Address		Box # or Apt. #	Month / Day / Year
City	County	Zip	Telephone Number
Marital Status		Sex	Ethnic Information (Optional)
<input type="checkbox"/> Widowed, Single or Divorced <input type="checkbox"/> Married <input type="checkbox"/> Married, Living Separately		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other
Spouse's Last Name (if Living)	First	Initial	Social Security Number
Spouse's Birthdate		Spouse's Ethnic Information (Optional)	
Month / Day / Year	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other		
Do you have other insurance that covers prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, name of other insurance _____			
Does your spouse have other insurance that covers prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, name of other insurance _____			
Do you have Medicaid? (Not Medicare) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, do you have a Medicaid spenddown? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your spouse have Medicaid? (Not Medicare) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, does your spouse have a Medicaid spenddown? <input type="checkbox"/> Yes <input type="checkbox"/> No			

(Please turn over and fill in other side)

NEED HELP? CALL TOLL-FREE: 1-800-332-3742

¿ NECESITA AYUDA? LLAME 1-800-332-3742

