

**MEDICARE BUY-IN APPLICATION  
(QMB, SLMB, ALMB, QDWI)**

NAME AND ADDRESS										
Name		<i>(first)</i>			<i>(m.i.)</i>			<i>(last)</i>		
Address		<i>(no.)</i>			<i>(street)</i>			<i>(city)</i>		<i>(zip code)</i>
Mailing Address <i>(if different)</i>		<i>(no.)</i>			<i>(street)</i>			<i>(city)</i>		<i>(zip code)</i>
Telephone Your # ( ) _____ Message # ( ) _____				Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed						
Are You Applying For <i>(check one)</i> <input type="checkbox"/> Self Only <input type="checkbox"/> Self and Spouse				Name of Spouse <i>(first)</i> <i>(m.i.)</i> <i>(last)</i>						
	Date of Birth	Place of Birth	Race	Social Security Number	Sex <i>(circle one)</i>		Maiden Name	Do You Have Medicare?		
					M	F		Part A <i>(circle one)</i>	Part B <i>(circle one)</i>	
Self								Y   N	Y   N	
Spouse					M	F		Y   N	Y   N	
INCOME										
Please list <u>gross</u> income received by you and your spouse. Income includes <u>gross</u> Social Security (including your Medicare Part B premium), SSI, wages, pensions, disability benefits, Worker's Compensation, unemployment compensation, interest, dividends, rental property income, alimony, child support, etc.										
SELF					SPOUSE					
Name and Address of Employer, if any:					Name and Address of Employer, if any:					
Name of Pension Company:					Name of Pension Company:					
Source	How Often Received (Weekly, Monthly or Quarterly)			Amount	Source	How Often Received (Weekly, Monthly or Quarterly)			Amount	
Social Security				\$	Social Security				\$	
SSI				\$	SSI				\$	
Wages <i>(enter gross)</i>				\$	Wages <i>(enter gross)</i>				\$	
Pension				\$	Pension				\$	
Annuity				\$	Annuity				\$	
Other <i>(describe):</i>				\$	Other <i>(describe):</i>				\$	
Other <i>(describe):</i>				\$	Other <i>(describe):</i>				\$	

### ASSETS

List all assets owned by you and/or your spouse. Include cash on hand (*money that is not in an account*), savings and checking accounts, certificates of deposit (C.D.), individual retirement accounts (I.R.A.), vacation and Christmas clubs, revocable and irrevocable burial funds/accounts or any other type of account where your name appears on the account (*even if the money is not yours*). Include accounts such as those for children or those held in trust for you. List other types of assets such as contents of a safe deposit box, mortgage payable to you, jewelry, furs, and/or paintings held for investment, etc. Under VEHICLES, list any car, truck, boat, camper, recreational vehicle, trailer, motorcycle or other vehicle (*include unregistered vehicles*) that you own or have registered in your name. Under INSURANCE POLICY OR DEATH BENEFIT please be sure to enter the face value (the amount that appears on your policy) and if it is a whole life policy, the cash surrender value.

Asset Type	Owner (self or spouse)	Name of Bank, Fund, etc.	Description	Account or Policy No.	Value
Cash on Hand					\$
Bank/Credit Union					\$
Bank/Credit Union					\$
Annuity					\$
Trust					\$
Revocable Burial Fund					\$
Irrevocable Burial Fund					\$
Stocks					\$
Bonds					\$
Other:					\$
Other:					\$
Other:					\$

### VEHICLES

Owner	Make	Model	Year	Value	Amount Owed on Loan
				\$	\$
				\$	\$
				\$	\$

### INSURANCE POLICY OR DEATH BENEFIT

First name of Policy Owner	Insurance Co.	Policy No.	Type (check one)	Face Value	Cash Value
			<input type="checkbox"/> Term <input type="checkbox"/> Whole Life	\$	\$
			<input type="checkbox"/> Term <input type="checkbox"/> Whole Life	\$	\$
			<input type="checkbox"/> Term <input type="checkbox"/> Whole Life	\$	\$

REAL ESTATE				
Address of Property Owned	Owner (self, spouse or joint)	Estimated Value	Amount Owed on Mortgage	Do you live in this property?
		\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

INHERITANCE	
Do you have an inheritance pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide details:

PENDING LAW SUIT	
Are you suing anyone?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide details, including the name of your attorney:

CITIZENSHIP						
	U.S. Citizen? (circle one)	If no, enter alien status, e.g., permanent resident, refugee, etc.	Alien Registration Number	Country of Origin	Place and Date of Entry into U.S.	Name of Sponsor (if applicable)
SELF	Y N					
SPOUSE	Y N					

**READ CAREFULLY AND SIGN**

I certify that all of the statements made in this application are true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to the penalties for false statements as specified in Connecticut General Statute Sections 53a-157b and 17b-97 and to penalties for larceny as specified in sections 53a-122 and 53a-123. I may also be subject to penalties for perjury under Federal law.

I understand and agree to the following:

- This application constitutes a request for Medicare Buy-In programs only (QMB, SLMB, ALMB and/or QDWI).
- If I wish to apply for the Department's other programs, such as cash assistance, Medicaid or Food Stamps, I must complete a separate application form.
- My Social Security number will be used to verify identity and eligibility. My Social Security number may also be used to cross-match information in federal, state and local government files.
- The information on this form is subject to verification by federal, state and local officials. The Department may conduct independent verification of the statements made by me on this application.
- The information available to the Department through the Income and Eligibility Verification System (IEVS) will be requested and used to process my request for assistance. This information will come from the Department of Labor, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. Information received may also be verified directly with other sources such as banks and employers. Results from such investigations may affect my eligibility and level of benefits.
- I agree to cooperate with state and federal personnel in a Quality Control Review.
- I must notify the Department within 10 days of any changes in my income or assets.
- The information given on this form is confidential and will only be used for purposes of program administration.
- I may request a fair hearing in writing if I disagree with an action taken on my case.
- I swear that I am a United States Citizen or, if I am not, that the information I have provided concerning my non-citizen status is true.
- I understand that false or misleading statements on this application violate federal law and may be punishable by a fine up to \$25,000 or imprisonment for 5 years, or both.
- I agree to an assignment of pending lawsuit money to the State for medical expenses related to the lawsuit and paid by QMB.
- I understand that by receiving medical assistance, I allow the State to recover the cost of my medical bills which may have been covered by other insurance directly from the insuring company.
- I understand that the State may recover monies from the estates of individuals who received medical assistance benefits and who do not have a living spouse or a surviving child who is under age 21 or blind or disabled.
- I give permission to any health insurer or provider to release information about me to the Department of Social Services. The information requested must concern my claim for medical benefits from the state.
- I will not alter, trade, sell, or use someone else's medical services identification card.
- I understand that my spouse, if I am separated from him or her, may be billed to repay the State for the cost of my medical care.

Applicant's Signature	Date	Spouse's Signature	Date
Conservator or other Representative's Signature, if applicable			Date

This application will be considered without regard to race, color, sex, age, physical or mental disability, religious creed, national origin, sexual orientation, ancestry, language barriers or political beliefs.

*THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.*