

Priority Health Medicare

Employer Group MAPD Eligibility Verification Form

(Please print)

Company
Contact person

Eligibility criteria:

- Subscriber **must** have Medicare Parts A & B.
- **For groups with more than 20 employees:** Subscriber does not meet eligibility requirements for active group benefits **or** has retired from the company.

Name of Subscriber	Date of Active Group Ineligibility or Retirement Date <i>Not required for groups with less than 20 employees</i>	Presently covered in your health plan?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Employer Signature _____ Date _____

Title _____