



1/15/2010

Ronald Lewandowski
21510 Lake St Clair Dr
Crest Hill, IL 60403

199109--

Member ID: 902659173*01

Dear Mr. Lewandowski:

The Centers for Medicare & Medicaid Services (CMS) has told us that **you may** have other health insurance coverage that should be your primary insurance. In order for AdvantraRx Premier Plus to update records accordingly, we are asking that you please fill out the working aged survey enclosed with this letter. It is important that you complete all of the sections that apply to you.

If the information that has been provided to us by CMS is incorrect, we will then use the data provided by you on the survey to update and correct Medicare's records. However, if the information is correct, we will use the data to update our records. In either case, your coverage through AdvantraRx will not change.

If you have any questions regarding this letter or your AdvantraRx Premier Plus plan, please contact AdvantraRx Premier Plus Customer Service at 1-888-736-0486, 24 hours a day, 7 days a week. TTY/TDD users should call 1-800-716-3231. Thank you for participating in our Plan; we value your membership.

Sincerely,

Government Programs Enrollment

Please Return Survey to:

AdvantraRx Premier Plus
PO Box 7763
London, KY 40742-9831

A Medicare approved Part D sponsor

CMS Working Aged Survey

Name: _____

Spouse's Name: _____

Medicare Number: _____

Spouse's Medicare Number: _____

1. Do you have other Rx Coverage? Yes No

If so, Name of other Rx Coverage? _____ Actively Employed? Yes No

Rx Group #: _____ Rx Id #: _____

2. Do you have health coverage through the Veteran's Administration (VA)?

Yes No

If yes effective date ___/___/___

3. Are you currently working or self employed? Yes No

→ If no, what is your retirement date? ___/___/___
(go to question 4)

→ If yes...

A. Do you have or have you ever had health coverage through this employer? Yes No

B. Does your employer have 20 or more employees? Yes No

C. Tell us about your employer:

Company: _____

Address: _____

Phone: _____

Employment Start Date: _____

D. Tell us about your insurance

Start Date: _____
(month/year)

End Date: _____
(month/year)

Group Number: _____

Company: _____

Address: _____

4. Are you married? Yes

If no, end of survey. No

If yes, please continue to fill out your spouse's employment information.

5. Is your spouse currently working or self employed? Yes No

→ If no, what is your spouse's retirement date? ___/___/___
(finished)

→ If yes...

A. Do you have or have you ever had health coverage through your spouse's employer? Yes No

B. Does your spouse's employer have 20 or more employees? Yes No

C. Tell us about your spouse's employer

Company: _____

Address: _____

Phone: _____

Employment Start Date: _____

D. Tell us about your spouse's insurance

Start Date: _____
(month/year)

End Date: _____
(month/year)

Group Number: _____

Company: _____

Address: _____

Signature: _____

Date: _____