

**MEDICARE CROSS-OVER ENROLLMENT FORM**

**Return To:**

Eligibility Operations  
Medicare Cross-over Program  
PO Box 30963  
Salt Lake City, UT 84130-0963  
Or Fax to: 248 733 6061

**Employer Name: Montgomery County Public Schools (MCPS)**

**Group Number: 704567      MCPS Employee ID Number: \_\_\_\_\_**

(Refer to your UnitedHealthcare ID card for help in completing the information above.)

Yes! I want to participate in the Medicare Cross-Over Program.

**Retiree/Participant: (Complete this section if you are the retiree OR if you are the only person enrolling in Medicare Cross-Over. PLEASE PRINT WITH BLACK OR BLUE PEN)**

Name \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_

Medicare Claim # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(Enter the Medicare Claim # as it appears on your Red, White and Blue Medicare Health Insurance Card)

**Spouse: (Complete this section only if your spouse, as the retiree, completed the above section and you also want to enroll in Medicare Cross-Over.)**

Name \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Medicare Claim # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(Enter the Medicare Claim # as it appears on your Red, White and Blue Medicare Health Insurance Card)