GOVERNMENT BENEFITS QUESTIONNAIRE

Emtal Talc Settlement c/o Verus LLC
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OUR FILE NO. 6626-1

I. PERSONAL INFORMATION

– If you are completing this form on behalf of a Claimant (as Parent, Guardian, Representative, POA, GAL, etc.), **complete this entire form using information for the Claimant and attach a copy of the documentation designating you as such. PLEASE WRITE LEGIBLY.**

Name: ______________________________ Date of Birth: ____/____/________
(First) (M.I.) (Last) mm/dd/year

Current Address: ______________________________

City: ______________________ State: ______ Zip: __________

Full SSN: ____________ Telephone: (______)________ Mobile: (______)__________
(Required)

Gender: **M** ☐ **F** ☐

Is the Claimant deceased? YES ☐ **NO** ☐ If yes, state your relationship to Claimant: ______________

II. SETTLEMENT INJURY INFORMATION

Date of your **FIRST** exposure: ______________ Date of your **LAST** exposure: ______________

****PROVIDE ALL DOCUMENTATION YOU HAVE OF YOUR FIRST EXPOSURE AND LAST EXPOSURE AS REQUIRED UNDER THE POD****

Date of onset of your first symptoms related to your settlement injury: ______________

City, State and County in which your exposure occurred: ______________

Briefly describe your injuries related to this case as diagnosed by a doctor: ______________

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III. GOVERNMENT BENEFIT INFORMATION

A. Are you eligible for ***MEDICARE (federally-sponsored)*** Parts A &/or B benefits (please answer regarding your eligibility to receive Medicare benefits even if you have a Medicare replacement plan in effect)? **YES** ☐ **NO** ☐
(If you are 65 or older or have been on disability for more than 24 consecutive months, you are usually automatically eligible.)

i. On what date did you become eligible for Medicare? ______________

ii. Please list your Medicare number (HICN or MBI): ______________

********PLEASE ATTACH A COPY OF YOUR MEDICARE CARD, IF AVAILABLE********

B. At the time of your **FIRST** date of exposure, were you eligible for or receiving ***MEDICAID (state sponsored, needs-based)*** benefits? **YES** ☐ **NO** ☐
(Answer **YES** even if benefits were **not** paid)(this includes Managed Care Organizations/Providers under the state Medicaid program)

i. Please provide the State that you receive your Medicaid benefits from?______________
ii. Please list your Medicaid number:______________
iii. If known, list your Medicaid Managed Care Organization: ______________

GOVERNMENT BENEFIT INFORMATION, CONT.

C. At any time after your **FIRST** date of exposure, were you eligible for or did you receive ***MEDICAID (state sponsored, needs-based)*** benefits (Please list **ALL** States if more than one)? **YES** ☐ **NO** ☐
(Answer **YES** even if benefits were **not** paid)(this includes Managed Care Organizations/Providers under the state Medicaid program)

i. Please provide the State that you receive your Medicaid benefits from?__________________________
ii. Please list your Medicaid number:____
iii. If known, list your Medicaid Managed Care Organization: ______________________________________

*********PLEASE ATTACH A COPY OF YOUR MEDICAID CARD(S)*********

D. Have your EVER received ***Military medical insurance (Tricare or CHAMPUS)***? **YES** ☐ **NO** ☐

If YES, are you the Sponsor or a Dependent? (circle one) **SPONSOR** **DEPENDENT**

If YES, in what branch of the Armed Forces did you or the sponsor serve? _______________________________

Sponsor Name and ID number: ____

Health program plan name (Prime, For Life, etc.): ____

E. Are you eligible to receive **ANY** medical treatment (not just service connected treatment) from a ***Veterans Administration ("VA") hospital or any other VA medical facility***? **YES** ☐ **NO** ☐

Do you have CHAMPVA? **YES** ☐ **NO** ☐

If YES to either question above, please list the names and locations (city and state) of all VA treatment facilities from which you have received ANY medical treatment, even if the medical treatment is not related to this case (attach additional pages, if needed):

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F. Do you have any other type of known ***government*** medical liens or known ***government*** medical insurance providers not listed on this questionnaire previously (i.e Indian Health Services)? **YES** ☐ **NO** ☐

If YES, please list the lienholder or government medical insurer and phone number:

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IV. MEDICARE PART C AND PART D PRIVATE MEDICAL BENEFIT INFORMATION

A. Have you ever had **Medicare Part C** health insurance <u>at the time of or after</u> your settlement-related personal injury/exposure? **YES** ☐ **NO** ☐
(This applies for <u>Medicare Part C and ANY Medicare Advantage or Medicare supplement plan</u>.)

If Yes, complete the following: (if you had more than 1 other insurance company, please list them on a separate sheet and attach)

Full name of your Medicare Part C company: ______________________________

Member ID #: ______________________________

Group #: ____________________ Policy #: ____________________

Insurance Company's phone #: (may be found on the back of your insurance card): ____________

Insurance Company's Address: ______________________________
Street

____
City State Zip

*******<u>PLEASE ATTACH A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD(S)</u>*******

B. Have you ever had **Medicare Part D** health insurance <u>at the time of or after</u> your settlement-related personal injury/exposure? **YES** ☐ **NO** ☐
(This applies for <u>Medicare Part C and ANY Medicare Advantage or Medicare supplement plan</u>.)

If Yes, complete the following: (if you had more than 1 other insurance company, please list them on a separate sheet and attach)

Full name of your private insurance company: ______________________________

Member ID #: ______________________________

Group #: ____________________ Policy #: ____________________

Insurance Company's phone #: (may be found on the back of your insurance card): ____________

Insurance Company's Address: ______________________________
Street

____
City State Zip

*******<u>PLEASE ATTACH A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD(S)</u>*******

If you have had additional Medicare Part C and/or Part D medical insurers since your date of injury that you have not listed in questions A or B above, please attach additional page(s) with information for any additional medical insurers you've had since your exposure date AND provide a copy of the front and back of your insurance card(s) for those insurers. <u>You are responsible for providing accurate information for any medical insurers you've had since your date of exposure.</u>

V. RELEASE AND SIGNATURE

By signing below, you agree to the release of the information given, and your name, address, Social Security Number, and date of birth to the Private and/or Governmental Agencies referenced in Parts III, IV and V above. It is your responsibility to notify us if any of your benefit information changes or needs to be supplemented. **The undersigned hereby swears under penalty of perjury that all of the information provided herein is true and accurate.** Your signature if an adult; Parent or Guardian's Signature if a Minor; or Personal Representative's Signature if Claimant is incapacitated or deceased:

____ Date: _______/_______/_______

Claimant's Signature
(or Representative's Signature)

If you are signing this document as a Representative, please state your relationship to the

Claimant:____

****If you have signed this document as a Representative, you must attach documents designating you as such.****

PLEASE MAKE SURE THAT YOU COMPLETE & RETURN
ALL PAGES OF THIS FORM.
MISSING OR ILLEGIBLE INFORMATION AND/OR PAGES WILL DELAY THE PROCESSING OF YOUR CLAIM.