

Return To:
Eligibility Operations
Medicare Cross-over Program
PO Box 1918
Oldsmar, Florida 34677

MEDICARE CROSS-OVER ENROLLMENT FORM

Suffolk Schools Employees Health Plan 710635

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

Retiree: (Please complete even if retiree is deceased)

(PLEASE PRINT)

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:

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)