Form Approved
OMB No. 0960-0696

Application for Help with Medicare Prescription Drug Plan Costs

THIS DOES NOT ENROLL YOU IN A MEDICARE PRESCRIPTION DRUG PLAN.

FOR OFFICIAL USE ONLY

State code: ☐☐ WBDOC Exception: ☐

1. Applicant's Name: Print name **as it appears on your Social Security card**. Use one box for each letter.

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

APPLICANT'S SOCIAL SECURITY NUMBER **APPLICANT'S DATE OF BIRTH (MM-DD-YYYY)**

2. If you are **married and living with your spouse**, please provide the following information **as it appears on your spouse's Social Security card**. If you are not currently married or do not live with your spouse, skip to question 3 and do not include any information about your spouse on this application.

FIRST NAME **MI**

LAST NAME **SUFFIX (Jr., Sr., etc.)**

SPOUSE'S SOCIAL SECURITY NUMBER **SPOUSE'S DATE OF BIRTH (MM-DD-YYYY)**

If your spouse has Medicare, does he or she also wish to apply for the extra help? ☐ **YES** ☐ **NO**

3. If you are married and living with your spouse, do you have savings, investments or real estate worth more than $25,010? If not married or you don't live with your spouse, do you have savings, investments or real estate worth more than $12,510? **DO NOT include the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.**

☐ **YES** If you place an ☒ in the **YES** box, **STOP**. You are not eligible for the extra help and you do not need to return this application to us. If you need a letter stating you are not eligible, sign the application on page 6 and return it to us.

☐ **NO or NOT SURE** If you place an ☒ in the **NO or NOT SURE** box, complete the rest of this application and return it to us.