Maryland Medical Assistance Program
Request for Life Insurance Information

SECTION I (To Be Completed By Case Manager)

Date: _____   **Case Manager**_____

CID# _____   **Telephone Number**_____

District Office (D.O.) _____   **D.O. Address** _____

_____

Name of Insurance Company

_____
Address

Customer Name _____

SSN _____ **D.O.B.**_____

SECTION II (To Be Completed By Applicant)

I AUTHORIZE THE RELEASE OF INFORMATION TO THE DEPARTMENT OF SOCIAL SERVICES

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Signature   **Date**

NOTICE TO MEDICAID APPLICANT

You are providing personal information (Name, Address, Date of Birth, Income History, Employment History, etc.) in this application Medicaid benefits. The purpose of requesting this personal information is to determine your eligibility for Medicaid.

If you do not provide this information, the Medicaid Program may deny your application for benefits. You have the right to inspect, amend or correct this personal information. The Medicaid Program will not permit inspection of your personal information, or make it available to others, **except** as permitted by law.

                                                         Name: _____

Please Complete Numbers 1-8

TO WHOM IT MAY CONCERN:
Please provide the following information regarding life insurance policies owned by applicant/spouse.
When completed and signed, please mail to office address listed on page 1 or fax to _____.

APPLICANT (AP) SSN_____
SPOUSE (SP) SSN_____

1. Name of Insured
   AP Policy (1)_____Policy (2)_____Policy (3)_____
   SP Policy (1) _____ Policy (2) _____ Policy (3) _____

2. Name of Policy
   AP Policy (1)_____Policy (2)_____Policy (3)_____
   SP Policy (1) _____ Policy (2) _____ Policy (3) _____

3. Policy Number
   AP Policy (1) _____Policy (2)_____ Policy (3)_____
   SP Policy (1) _____ Policy (2) _____ Policy (3) _____

4. Original Face Value
   AP Policy (1) _____ Policy (2) _____ Policy (3) _____
   SP Policy (1) _____ Policy (2) _____ Policy (3) _____

5. Accumulated Face Value
   AP Policy (1) _____ Policy (2) _____ Policy (3)_____
   SP Policy (1)_____ Policy (2) _____ Policy (3)_____

6.Loan(s) Against
   AP Policy (1) _____ Policy (2) _____Policy (3)_____
   SP Policy (1)_____Policy (2) _____ Policy (3) _____

7. Has additional insurance been purchased with dividends?
   AP Policy (1) _____Policy (2) _____Policy (3) _____
   SP Policy (1) _____ Policy (2) _____ Policy (3) _____

8. Total Cash Value   Does this amount include #5 above? Yes☐ No☐
   AP Policy (1) _____ Policy (2) _____ Policy (3) _____
   SP Policy (1) _____Policy (2) _____ Policy (3)_____

_____   _____
Signature of Representative of Insurance Company   Date

_____   _____
Title   Telephone Number