

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

## MEDICARE CROSS-OVER ENROLLMENT FORM

**ConEdison, Inc.**  
**Customer Number: 706538**

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

<b>Retiree:</b> (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)	

<b>Spouse:</b>	
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)	