

OLIVER V. MONSANTO AND TOLBERT V. MONSANTO SETTLEMENT  
MEDICAID QUESTIONNAIRE

PLEASE COMPLETE AND RETURN TO:

CLAIMS ADMINISTRATOR PAYMENT OFFICE  
TOLBERT QUALIFIED SETTLEMENT FUND  
Suite 1200  
2 North 20th Street  
Birmingham, Alabama 35203

I. CLAIMANT INFORMATION

Claimant Name: \_\_\_\_\_  
(Last Name) (First Name) (Initial)

Claimant Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Claimant Social Security Number: --

Claimant Current Address: Apt. No. (If Applicable) \_\_\_\_\_  
Street \_\_\_\_\_  
(Number) (Street Name)  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Daytime Evening Mobile/Cell

Home Mail Address \_\_\_\_\_ (Optional)

II. MEDICAID QUESTIONS

Have you been eligible for Medicaid at any time in the last ten (10) years? YES \_\_\_ NO \_\_\_  
If you answered YES to question 1, list your thirteen digit Medicaid number \_\_\_\_\_  
Has Medicaid ever paid any of your hospital or doctor bills? YES \_\_\_ NO \_\_\_

III. PARTIAL CONSENT TO RELEASE OF SOCIAL SECURITY NUMBER AND OTHER INFORMATION, CERTIFICATION AND SIGNATURE

If you answered YES in response to the first question in Part II, above, then, by signing below, you agree to the release of the information given in Part II, and your name, address and social security number to the Alabama Medicaid Agency or other State Medicaid Agency.

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 Deceased:

\_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

WITNESS NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_