Massachusetts
Department of
Public Welfare

THIRD PARTY LIABILITY INDICATOR

Date: ______________

☐ Open ☐ Reopen
CAT ______ ☐ Ongoing

To: Third Party Liability Unit

From: ______________________ ______ ______
Worker's Name (please print) Region LWO #

Re: ______________________
Case Name (Last, First, MI)

______________ ( ) ______________
Social Security Number Telephone Number

Attached:

☐ CA/CS

☐ MA Application page(s) ______

☐ AFDC Application page(s) ______

☐ GR Application page(s) ______

1. ☐ Update to insurance status ☐ Insurance policy cancelled

2. Health Insurance Information *(Complete this for all persons included in this case, **including the absent parent**, except for Medicare or Health Choices enrollees.)* List the names of the dependents covered by this policy on the reverse side. *(Complete a separate form for each **Health Insurance** policy.)*

______ ______ ______ ______ / /
Policy Holder's Name Relationship to Case Name Insurance Company Name Policy Number/Group Number Effective Date

3. Absent Parent or Spouse Information (List the dependents of this absent parent on the reverse side.) *(Complete a separate form for each absent parent.)*

______ – – ______ ______
Name (last, first) Social Security Number Address/Zip

______ ______
Employer's Name Employer's Address/Zip

4. Armed Forces Information *(Complete for all persons included in this case who have served.)*

______ ______ ______ ______ ______
Name (last, first) Branch of Service Station/Location Date of Discharge VA/ID Number

5. Employment Information *(Complete for all persons included in this case who are employed.)* ☐ Employed Full-Time ☐ Employed Part-Time

______ ______
Name (last, first) Employer's Name and Address

6. Medicare Part B Buy-In ☐ Add ☐ Delete Action Reason ______ Sex ______
categories 5 and 7 only) (12, 13, 15) (M/F)

Effective Date ___/___
MM YY

☐☐☐☐–☐☐–☐☐☐☐–☐☐
Medicare Claim Number Suffix

TPLA (2/90)
16-021-0290-