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## Benefits Update Form

**Please complete this form to help us better understand your current coverage.**

Beneficiary Name: \_\_\_\_\_

### **Social Security Information**

Does Beneficiary receive Supplemental Security Income (SSI)?      Yes      No

Does Beneficiary receive Social Security Disability Insurance (SSDI)?      Yes      No

Does Beneficiary receive Medicaid benefits?      Yes      No

**A. If you are receiving Medicaid, please specify your Medicaid ID number (if available):** \_\_\_\_\_

Does Beneficiary receive Medicare benefits?      Yes      No

**B. If you are receiving Medicare, please specify your Medicare ID number (if available):** \_\_\_\_\_

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### **Additional Information**

9. Are you currently enrolled in any other assistance programs? (e.g., SNAP, Housing Assistance)

- Yes
- No
- If yes, please specify: \_\_\_\_\_

10. Is there any other information you would like us to know regarding your benefits or health insurance coverage?

- \_\_\_\_\_
- \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_