Form Approved
OMB No. 0938-0787
Expires: 06/2023

REQUEST FOR EMPLOYMENT INFORMATION

WHAT IS THE PURPOSE OF THIS FORM?

In order to apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse's current employment. People with disabilities must have large group health plan coverage based on your, your spouse's or a family member's current employment.

This form is used for proof of group health care coverage based on current employment. This information is needed to process your Medicare enrollment application.

The employer that provides the group health plan coverage completes the information about your health care coverage and dates of employment.

HOW IS THE FORM COMPLETED?

- Complete the first section of the form so that the employer can find and complete the information about your coverage and the employment of the person through which you have that health coverage.
- The employer fills in the information in the second section and signs at the bottom.

WHAT DO I DO WITH THE FORM?

Fill out Section A and take the form to your employer. Ask your employer to fill out Section B. You need to get the completed form from your employer and include it with your Application for Enrollment in Medicare (CMS-40B). Then you send both together to your local Social Security office. Find your local office here: www.ssa.gov.

GET HELP WITH THIS FORM

- Phone: Call Social Security at 1-800-772-1213
- En español: Llame a SSA gratis al 1-800-772-1213 y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- In person: Your local Social Security office. For an office near you check www.ssa.gov.

:PV IBWF UIF SJHIU UP HFU .FEJDBSF JOGPSNBUJPO JO BO BDDFTTJCMF GPSNBU MJLF MBSHF QSJOU #SBJM
ZPV WF CFFO EJTDSJNJOBUFE BHBJOTU 7JTJU IUUQT XXX NFEJDBSF HPW BCPVU VT BDDFTTJCJMJUZ OPOEJ
GPS NPSF JOGPSNBUJPO 55: VTFST DBO DBMM

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name

2. Date
__ __ / __ __ / __ __ __ __

3. Employer's Address

City

State

Zip Code

4. Applicant's Name

5. Applicant's Social Security Number
___ – __ __ – ____

6. Employee's Name

7. Employee's Social Security Number
___ – __ __ – ____

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? Yes No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
__ __ / __ __ __ __

3. Has the coverage ended? Yes No

4. If yes, give the date the coverage ended. (mm/yyyy)
__ __ / __ __ __ __

5. When did the employee work for your company?

From: (mm/yyyy)
__ __ / __ __ __ __

To: (mm/yyyy)
__ __ / __ __ __ __

Still Employed: (mm/yyyy)
__ __ / __ __ __ __

6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.

From: (mm/yyyy)
__ __ / __ __ __ __

To: (mm/yyyy)
__ __ / __ __ __ __

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? Yes No

2. If yes, does the applicant have hours remaining in reserve? Yes No

3. Date reserve hours ended or will be used? (mm/yyyy)
__ __ / __ __ __ __

All Employers:

Signature of Company Official

Date Signed
__ __ / __ __ / __ __ __ __

Title of Company Official

Phone Number
(___) ___ – ____

STEP BY STEP INSTRUCTIONS FOR THIS FORM

SECTION A:

The person applying for Medicare completes all of Section A.

1. Employer's name:
   Write the name of your employer.
2. Date: