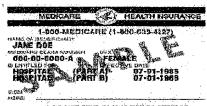
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you, a spouse, or other family members covered by your group health plan have, or has ever had, a similar Medicare card.

Section I:



DO NOT BEND CLAIMS FOR PAYMENT OF

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	□Yes	□No						
If ves please complete the following. If no proceed to Section II								
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available	able.) .	1						
Medicare Claim Number: Date of Birth (Mo/Day/Year)	- -							
Social Security Number: Sex	□Female	□Male						
(If Medicare Claim Number is Unavailable)								
Section II:	3? □Yes	□No						
Do you have a spouse that is presently, or has ever been, enrolled in Medicare Part A or Part E								
If yes, please complete the following. If no, proceed to Section III. Full Name: (Please print the name exactly as it appears on their SSN or Medicare card if available to the control of the control o	ahle.)	Feff.						
HUII Name: Prease print the Hame exactly as it appears of their source interesting the conditions of t								
Medicare Claim Number: - - Date of Birth	- - -							
(Mo/Day/Year)								
Social Security Number: Sex	□Female	□Male						
(If Medicare Claim Number is Unavailable)								
Section III:	□Yes	□No						
Do you have another covered family member that is presently, or has ever been, enrolled in	D169							
Medicare Part A or Part B? If yes, please complete the following. If no, proceed to Section IV. If additional space is needed.	d for completion	of this						
section please attach another sheet								
Full Name: (Please print the name exactly as it appears on their SSN or Medicare card if available	able.)							
Relationship (Dependent child, domestic partner, etc.):								
Medicare Claim Number: Date of Birth (Mo/Day/Year)								

Social Security Number:				-		-				Sex	□F	emale	€	□1	/lale
(If Medicare Claim Number is Unavaila	ble)		Ш.		!	Ш					1			. <u>l</u>	
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Name of Person Completing This Fo	rm (Please I	Pri	nt)		_										
C'	Form		į	Date											
Signature of Person Completing This															
If you have completed Sections I – IV a proceed to Section V.	bove, stop h	ere	e. If yo	u are	refus	ing to	pro	<i>ide</i>	the	inforn	natioi	ı requ	ieste	d in S	Sections I
Section V:		_													
Subscriber Name (Please Print)				Subs	cribe	r's P	lan li)							
For the reason(s) listed below, I have no I do not provide the requested informati benefits to pay my claims correctly and	ion, I may be	he vio	inform plating	ation oblig	reque ations	ested s as a	l. I un a ben	ders efici	star iary	nd that to ass	if I a sist M	m a M ledica	ledic re in	are b coor	eneficiary dinating
Reason(s) for Refusal to Provide Rec	quested Info	orm	ation:				_								_
Name of Person Completing This For	rm (Please F	_ Prir	ıt) :	Signa	ture	of Pe	ersor	Co	mp	leting	This	Forn	n / D	ate	