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.

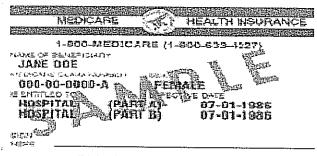
Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information 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 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,

similar Medicare card.



DO NOT SEND CLARKS FOR PAYMENT OF MEDICARE BENEATS TO THIS ILL ADDRESS

Section I:																				
Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?												П	7	es.		Τľ	No			
If yes, please complete the following. If no, proceed to Section II.												E /3						Postalena		
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available.)																				
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Medicare Claim Number:						7		T	Date of Birth							一十	<u> </u>	_!	'	
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						<u>l</u>					Ш								LJ 14	1410
Section II: Do you have a spouse that is presently, or has ever been, enrolled in Medicare Part A or Part B? Yes No																				
Do you have a spouse that is p	resently	, or has e	ver be	en, e	nrol	led in	n Med	lica	ire Pa	ırt A	or I	art B	?	Ē] ?	Zes.		\top [No	
If yes, please complete the following. If no, proceed to Section II																				
Full Name: (Please print the name exactly as it appears on their SSN or Medicare card if available.)																				
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Medicare Claim Number:		' 		7 7	1	_ _		╁	Date	of F	lirth	<u> </u>	- 	Т	\vdash	ᆛ	— <u>I</u> -	—	Щ.	
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Social Security Number:	_1	!		1	T^{\perp}	\sqcap	╁┼		(1110)	Lay	T	<u> </u>	7 1	\dashv		_	L	_ _		
(If Medicare Claim Number is Unavailable)										-			Se	x		Fei	male		□ м	Iale
Section III:																				
Do you have another covered family member that is presently, or has ever been, enrolled in										in		7 7	Zes		Т	No	·			
Medicare Part A or Part B?														╽┕				-		
If yes, please complete the fol	llowing.	If no bi	roceen	to S	ecti	on II	If n	ddi	tionio	/ cm	rce i	s noo	ded.	for:	(julipa ja	in I	1100	or.	i i i i i i i i i i i i i i i i i i i	2465
please attach another sheet.	MARLY.		NOTE:	LIVE .	78/9						113				10//	ριε	が対		ms se	Luum
Full Name: (Please print the	пате ех	actly as	it app	ears	on ti	ieir S	SSN o	N	fedic	are i	ar A	if ave	ilah	7a.)		oren Garan	400	13,744-15 1,78,155	Palencala Mariatan	HALLING C
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Relationship (Dependent Child, domestic partner, etc.):																				
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(If Medicare Claim Number is Unavailable)							-		-	-			Se	x		Fe	male	e	Пм	[ale

Full Name: (Please print the name exactly as it appears on	their SSN or Medicare card if available	Sisalyan y
		C 1992-1971
Relationship (Dependent Child, domestic partner, etc.):		
P 12 specialist circuit, domestic partner, etc.y.		
Medicare Claim Number:	_ Date of Birth	Т Т
Social Security Number:	(Mo/Day/Year)	
(If Medicare Claim Number is Unavailable)	Sex Female	Male
	Tenare L	
Full Name: (Please print the name exactly as it appears on	their SSN of Medicare card if available)	
Relationship (Dependent Child, domestic partner, etc.):		
Medicare Claim Number:	_ Date of Birth	
Social Security Number:	(Mo/Day/Year)	
(If Medicare Claim Number is Unavailable)	Sex Female	Male
Section IV:		
I understand that the information requested is to assist my in accurately coordinate benefits with Medicare and to meet its	surer, third-party administrator or group health plan to	
	topotting congations under releasence law.	
Subscriber name (Please Print)	Subscriber's Plan ID	
(Louiso 1 Time)	Subscriber & Fram ID	
Name of Payson Completing This Fig. (7)		
Name of Person Completing This Form (Please Print)		
Signature of Person Completing This Form	Date	
If you have completed Sections I – IV above, stop here. If y	ou are refusing to provide the information requested in	
Sections I – IV, proceed to Section V.		
Section V:		
Subscriber Name (Please Print)	Subscriber's Plan ID	
` '		
For the reason(s) listed below, I have not provided the inform	mation requested. I understand that if I am a Medicare	
beneficiary and I do not provide the requested information, l Medicare in coordinating benefits to pay my claims correctly	may be violating obligations as a beneficiary to assist	
Reason(s) for Refusal to Provide Requested Information	<u>:</u>	
100		
_		
Name of Person Completing This Form (Please Print)		
or i cross Completing This Form (Please Print)	Signature of Person Completing This Form / Date	