Certification of Medicare Status

Please complete **Section 1, and either Section 2, 3 or 4**. Sign and date the form and return it to CalPERS at address listed below. Please complete this form for each Medicare-eligible participant.

Section 1: Please enter the Member's/Dependent's name and Social Security Number

CalPERS Retiree Name:	**CalPERS Retiree Social Security Number:** _____ - _____ - _____
Member/Dependent Age 65 or older:	**Member/Dependent Social Security Number:** _____ - _____ - _____

Section 2: For Member/Dependent Enrolled in Medicare Parts A and B

☐ I am enrolled in Medicare Part A and Medicare Part B. This is the information reflected on my red, white, and blue Medicare card or Notice of Entitlement from the Social Security Administration:

Name of Medicare Beneficiary	_____
Medicare Claim Number	_____ - _____ - _____ - _____
HOSPITAL (PART A) effective date	_____ - _____ - _____
MEDICAL (PART B) effective date	_____ - _____ - _____

Section 3: For Member/Dependent claiming Medicare Ineligibility

☐ I am not eligible for premium-free Medicare Part A (in my own right or through a spouse). I have verified this with the Social Security Administration and have attached documentation of this fact. (Check all boxes that apply to you.)

☐ I did not work for any Social Security covered employment.

☐ I worked for Social Security covered employment, but have less than 40 quarters.

☐ I do not have a spouse (current, former or deceased) that qualifies me for Medicare Part A.

Section 4: For Member/Dependent who works and has Employer Group Health Plan coverage

☐ I have deferred Medicare Part B enrollment due to working beyond age 65 and have coverage in my/my spouse's Employer's Group Health Plan and have attached documentation of this fact.

1. Name of your current employer
   _____
2. Name of your Group Health Plan provided by your employer
   _____

Under penalty of perjury, I certify that the above information is true and complete.

_____ _____

Signature Date

(_____)_____

Daytime telephone number

Health Account Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS 225-7377

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