P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) |Fax (800) 959-6545
www.calpers.ca.gov

California Public Employees' Retirement System

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 P.O. Box 942715, Sacramento, CA 94229-2715.

Section 1: Please enter the Member's/Dependent's name and CalPERS ID.

CalPERS Retiree Name:	**CalPERS Retiree CalPERS ID:**
Medicare-Eligible Member/Dependent:	**Member/Dependent CalPERS ID:**

Section 2: For Member/Dependent Enrolled in Medicare Part 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 the work history of a current, former or deceased spouse). I have verified this with the Social Security Administration and have attached documentation of this fact.

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

_____

Section 5: Member/Dependent Signature

I certify that the above information is true and correct.

_____ _____

Signature Date (mmddyyyy)

_____

Daytime telephone number

Revised 08/13