California Service Employees Health and Welfare Trust Fund

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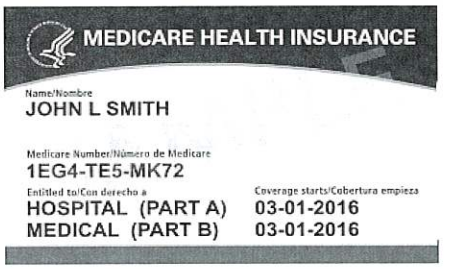
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP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


MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a — Coverage starts/Cobertura empieza
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016

Section I:

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, 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.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	
Social Security Number *(If Medicare Claim Number is Unavailable):*	**Sex:** ☐ Female ☐ Male	

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide last 5 digits of your SSN in the section above.

Section II:

Do you have a spouse that is presently, or has ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section III.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card, if available.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	
Social Security Number *(If Medicare Claim Number is Unavailable):*	**Sex:** ☐ Female ☐ Male	

Section III:

Do you have another covered family member that is presently, or has ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section IV. If additional space is needed for completion of this section, please attach another sheet.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card, if available.)*		
Relationship: (Dependent child, domestic partner, etc.):		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	
Social Security Number *(If Medicare Claim Number is Unavailable):*	**Sex:** ☐ Female ☐ Male	

Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card, if available.)*	
Relationship: (Dependent child, domestic partner, etc.):	
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**
Social Security Number *(If Medicare Claim Number is Unavailable):*	**Sex:** ☐ Female ☐ Male

Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card, if available.)*	
Relationship: (Dependent child, domestic partner, etc.):	
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**
Social Security Number *(If Medicare Claim Number is Unavailable):*	**Sex:** ☐ Female ☐ Male

Section IV:

I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____ _____

Subscriber Name *(Please Print)* **Subscriber's Plan ID**

_____

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 you 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 information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information

Name of Person Completing This Form (Please Print) **Signature of Person Completing This Form/Date**