

REQUEST FOR EMPLOYMENT INFORMATION**SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)**

1. Employer's Name		2. Date	
		/ /	
3. Employer's Address			
City		State	Zip Code
4. Applicant's Name		5. Applicant's Social Security Number	
		- -	
6. Employee's Name		7. Employee's Social Security Number	
		- -	

SECTION B: To be completed by Employers**For Employer Group Health Plans ONLY:**

1. Is (or was) the applicant covered under an employer group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. If yes, give the date the applicant's coverage began. (mm/yyyy)		
/		
3. Has the coverage ended? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. If yes, give the date the coverage ended. (mm/yyyy)		
/		
5. When did the employee work for your company?		
From: (mm/yyyy)	To: (mm/yyyy)	Still Employed: (mm/yyyy)
/	/	/
6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.		
From: (mm/yyyy)	To: (mm/yyyy)	
/	/	

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. If yes, does the applicant have hours remaining in reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Date reserve hours ended or will be used? (mm/yyyy)	
/	

All Employers:

Signature of Company Official		Date Signed
		/ /
Title of Company Official		Phone Number
		() -

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