

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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J Elliott



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