RETIREMENT PACKET

Thank you for your dedication!

You must meet one of the following TCRS qualifications to retire:

- Full retirement – 60 years old with 5 years of service (vested) OR 30 years of service
- Early retirement – 55 years old with 5 years of service (vested) OR 25 – 29 years
- Disability retirement – 5 years of service (vested) OR approved accident on the job
  - To continue health insurance, you must meet the eligibility and be on an approved Leave of Absence (LOA) – while your application is pending w/TCRS

Where do I begin?

- Log into your MSCS Employee Portal to submit your intent to retire (www.scsk12.org)

- Log into Tennessee Consolidated Retirement System (https://mytcrs.tn.gov) to submit your Retirement Application (within 5-7 business days from submitting your intent to retire)

Next Steps:

- Carefully review the following information (if applicable) in your Retirement Packet:
  - Qualifications for retirement and insurance at retirement
  - Retiree Health Information
  - Minnesota Life Beneficiary form (only if you have basic life insurance)

- Submit the following forms directly to MSCS Benefits:
  - Retirement Notification form (signed by supervisor)
  - Application for Retiree Health Insurance Enrollment/Change Form
  - Copy of Medicare card (if applicable) for retiree and dependent(s)
  - You must keep your insurance payments current (to prevent cancellation)
  - Basic life Insurance election form (if eligible)

For Additional MSCS Information: www.scsk12.org

Office of Benefits & Compensation - Retirement
160 S. Hollywood St., Barnes Building - Room 108, Memphis, TN 38112
PHONE: (901)416-5344 - FAX: (901)416-6463

For Additional TCRS Information: www.treasury.tn.gov/tcrs

If you have not received a letter from TCRS within 30 days of submitting your retirement application, it is strongly recommended that you follow-up on your status by calling TCRS at 1-800-922-7772 or logging into your TCRS account

RETIREMENT & INSURANCE QUALIFICATIONS

TCRS RETIREMENT QUALIFICATIONS:

- Full retirement –60 years old with 5 years of service (vested) **OR** 30 years of service
- Early retirement – 55 years old with 5 years of service (vested) **OR** 25 – 29 years of service
- Disability retirement – 5 years of service (vested) **OR** approved accident on the job (must meet the insurance eligibility and be on approved LOA while disability retirement is pending with TCRS to maintain health coverage at approval)

****

CURRENT INSURANCE REQUIREMENT FOR BOTH SCS AND MCS EMPLOYEES AS OF 7/1/2013:

- **Health Insurance - If "hired" after 7/1/2013: Required to complete (15) years of continuous service with the District and participate in a health plan offered by the District for the two (2) years immediately prior to retirement (subject to change with policy changes)**

- **Life Insurance - If "retired" after 9/1/2013: Required to have basic life insurance prior to retirement. Life insurance coverage is 50% of your active coverage amount at the time of retirement (not to exceed $50,000) – you pay 25% of the cost OR you may elect $10K coverage at no charge (policy subject to change with policy changes)**

****

RETIREE INSURANCE QUALIFICATIONS FOR **LEGACY SCS** EMPLOYEES:

- Health Insurance - If hired prior to 7/1/2013: Required to complete (15) years of continuous service with the District and participate in a health plan offered by the District prior to retirement
    - Teachers: Can complete a combination of (10) years of service with another school district (as reflected in TCRS or the Tenn Dept of Educ records) **and** complete five (5) years of continuous service with Shelby County Schools immediately prior to retirement

RETIREE INSURANCE QUALIFICATIONS FOR **LEGACY MCS** EMPLOYEES:

- Health Insurance - If hired prior to 1/1/2007: Required to be covered continuously by a health plan offered by either MCS or SCS or some combination thereof for the five (5) years immediately prior to retirement

- Health Insurance - If hired after 1/1/2007: Required to be covered continuously by a health plan offered by either MCS or SCS or some combination thereof for the ten (10) years immediately prior to retirement

Revised 02/17/2017

2024 Retiree Health Information

Eligible employees must complete an enrollment form to continue benefits with Memphis- Shelby County Schools. *Eligible employees must be enrolled in the MSCS Retiree Medical Insurance to participate in the dental and/or the vision plan.*

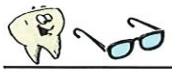
NOTE: Should you lose coverage or cancel medical, dental and/or vision benefits for yourself and/or a dependent, you will NOT be allowed to reinstate coverage at any time (even if you lose coverage elsewhere). There is no qualified event period to add your spouse/dependent(s) to retiree coverage (even if they lose coverage elsewhere). To continue dependent coverage at retirement, the dependent(s) must be enrolled in your active health plan prior to retirement.

Pre-65 Retirees - 3 Medical Plans Offered

Medical Plans	Retiree ONLY	Retiree + 1	Family
OAP In-Network Plus	$299.56	$599.11	$835.76
OAP Basic Option	$271.87	$543.73	$758.49
Choice Fund HRA Option	$246.27	$492.52	$687.07

Please note: Prior to your 65th birthday, you must enroll and provide a copy of your Medicare A&B card to Benefits to continue your coverage with Memphis-Shelby County Schools.

Dental & Vision for Pre-65 and Post-65 Retirees



DENTAL & VISION COVERAGE – You cannot add dental/vision coverage, if you did not have it prior to retirement. Your premium for dental and/or vision will be deducted from your TCRS retirement check. You must be enrolled in the MSCS Retiree Medical Insurance to participate in the dental and vision coverage. Listed below are the costs:

SCS DPPO ($1500) Option (DENTAL ONLY)	RETIREE ONLY	Retiree + 1	Family
SCS Basic Dental	$25.79 (per month)	$54.17	$77.38
SCS Vision Plan	$5.10 (per month)	$9.77	$15.84

For Additional MSCS Retiree Health Information go to www.scsk12.org – Employee Benefits

Basic Life Insurance

Retirees are required to have basic life insurance prior to retirement to continue coverage at retirement. The coverage is 50% of your active coverage amount at retirement (you pay 25%) OR $10K coverage at no charge. To inquire about continuation of supplemental life insurance, log onto www.lifebenefits.com/continue (Policy Number: 34548) (Access Key: shelbycty) or call 1-866-365-2374. Supplemental life insurance coverage election must take place within 31 days from your last day of coverage.

Post-65 Retirees

If you are Medicare eligible at retirement, you **must be** enrolled in Medicare A&B to continue coverage with the Memphis-Shelby County School's medical program. You must provide a copy of your Medicare A&B card.

What is the Cigna Medicare Advantage PPO plan?

This is a Medicare Advantage Health Maintenance Organization (PPO) with Part D prescription drug coverage. Medicare Advantage "replaces" Medicare Parts A&B

- Retiree continues to pay Medicare B premium
- Lower premium due to managed care approach
- End stage renal (cannot participate if pre-existing)
- Silver and Fit benefit
- Retiree has one (1) identification card (includes medical & prescriptions)
- Failure to sign up for Medicare A&B could cause a delay in your MSCS coverage or may even cause termination of your benefits with MSCS.
- You can only be in one medical supplement and prescription drug plan at a time. If you attempt to have multiple supplemental/prescription plans, your coverage with MSCS will terminate.

If your doctor won't accept the plan, call Customer Service at the phone number below. Cigna will reach out to the doctor on your behalf to explain how the plan works. In most cases, this will resolve the issue. The Medicare Advantage PPO is a great choice for you if:

1. Your medical providers are in the CIGNA network (you can ask your provider if they participate in the CIGNA Medicare Advantage PPO network, or look up your provider at www.CIGNAMedicare.com/group/MAresources.com) OR

2. Your medical provider will agree to bill CIGNA for their services (ask your provider) OR

3. You take the preventive medications or the diabetic medications that the Advantage PPO plan covers for free (check for these drugs at www.cignaMedicare.com/group/MAresources.com What if my provider does NOT agree to bill CIGNA for my services? Call CIGNA customer service: they may be able to help. They can be reached at 888-281-7867 or by e-mail at letushelpyou@cigna.com

Post-65 Retirees - Medicare Advantage PPO Plan

Classified	Monthly Premium
Retiree with Medicare	$122.00
Retiree+1 with Medicare	$244.00
Family with Medicare	$366.00
Certified - Less than 15 years of service	
Retiree with Medicare	$122.00
Retiree+1 with Medicare	$244.00
Family with Medicare	$366,00
Certified-15-19 years of service ($25.00 credit) w/Medicare A&B	
Retiree with Medicare	$97.00
Retiree+1 with Medicare	$219.00
Family with Medicare	$341.00
Certified-20-29 years of service ($37.50 credit) w/Medicare A&B	
Retiree with Medicare	$84.50
Retiree+1 with Medicare	$206.50
Family with Medicare	$328.50
Certified - 30 or more years of service ($50 credit) w/Medicare A&B	
Retiree with Medicare	$72.00
Retiree+1 with Medicare	$194.00
Family with Medicare	$316.00

Please note: Prior to your 65th birthday, you must enroll and provide a copy of your Medicare A&B card to Benefits to continue your coverage with Memphis-Shelby County Schools.

SUBMITTING YOUR MSCS INTENT TO RETIRE

(EMPLOYEE PORTAL)

Instructions for Active employees ready to retire

Step 1: Log into the Employee Portal

Step 2: Locate required Benefits retirement documents by clicking on "Documents/Links". Print, complete, and scan the following:

- Retirement Notification (must be signed by supervisor)
- Retiree Health Enrollment Form (if eligible)
- Basic Life Insurance Option Form (if eligible)
- Basic Life Insurance Beneficiary Form (if eligible)

***** Please contact MSCS Benefits at 901-416-5344 to confirm your eligibility for health and basic life insurance at retirement. ******

Step 3: Click 'Resignation/Retirement"

Step 4: Select "Retirement"

Step 5: Enter your Separation Date and Separation Reason

- Individuals who are applying for Disability Retirement, must contact MSCS Benefits via email at benefits@scsk12.org or by phone at 901-416-5344.

Step 6: Under "Attachments", click on Select to attach your completed Benefits retirement documents

- **Please read if documents are not complete:** If your documents are not completed when you start your retirement intent submission, click on *Save, I'm not finished* to return once documents are ready to be attached.

Step 7: Click on "Submit" to complete your online intent

Step 8: After you submit your intent, you will receive an email notification

Please note: You will not be able to complete the required documents online. They must be printed, completed, scanned as a PDF, and attached to your intent.

SUBMITTING YOUR TCRS

RETIREMENT APPLICATION ONLINE

In order to complete the retirement process, you must log into Tennessee Consolidated Retirement System (TCRS) and submit your electronic retirement application (within 5-7 days from submitting your intent to retire).

Step 1: Log into https://mytcrs.tn.gov and select "Online Retirement" from the Service menu

Step 2: Member verifies their address, beneficiary, and contact information

Note: To update the address, beneficiary, or contact information the member will be redirected to a page outside of the application. After changes are saved the member will be returned to the main page to start over.

Step 3: Member makes a benefit option selection

Members are encouraged to schedule a retirement counseling appointment and request a benefit estimate to determine which selection best fits their financial needs by calling 1-800-922-7772.

Step 4: Input bank account information for direct deposit

Step 5: Input tax withholding selection

Step 6: Review and submit the application

If you need assistance submitting your Online Retirement Application, please contact TCRS at 1-800-922-7772 directly and speak to a representative

SERVICE OR EARLY RETIREMENT NOTIFICATION

☐ Legacy MCS Employee ☐ Legacy SCS Employee ☐ MSCS Employee

Name: _____ SSN: ___-___-____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Personal Email: _____

Work Location: _____ Position: _____

Retirement Effective Date (required – LAST DAY WORKED): _____

Please read the following information carefully, providing your signature below certifies that you have read and clearly understand the following:

- I MUST meet one of the retirement qualifications below to be eligible to retire:
  - Full retirement –60 years old with 5 years of service (vested) OR 30 years of service
  - Early retirement – 55 years old with 5 years of service (vested) OR 25 – 29 years of service
  - Disability retirement – 5 years of service (vested) or approved accident on the job
    (Please note: you must be on an approved LOA to continue health insurance – if you meet the qualifications)
- If this Retirement Notification is submitted but I DO NOT meet the above qualifications, I understand that this form may be processed as a resignation.
- I have contacted Tennessee Consolidated Retirement System at 1-800-922-7772 to check my eligibility for retirement.
- I have requested an estimate of my retirement benefits from Tennessee Consolidated Retirement System.
- Teachers shall give a written notice of retirement at least thirty (30) days before the effective date of retirement to remain in good standing.
- Once this form is submitted, I understand that I must go through a process to rescind my application and that my information has to be approved by Human Resources. This includes cancelling retirement and/or changing my date of retirement (requests to rescind are not automatically approved).
- In order to have my retirement application processed completely and in a timely manner, I MUST complete and submit this form and other Benefit required documents.

Employee Signature (required): _____ Date: _____

Supervisor Signature (required): _____ Date: _____

PLEASE SUBMIT RETIREMENT INFORMATION TO:

Memphis-Shelby County Schools
160 S. Hollywood St.; Barnes Building - **ROOM 108**
Memphis, TN 38112-4892
Office of Benefits & Retirement

OFFICE: (901) 416-5344 or 416-5464 **FAX:** (901) 416-6463

MEMPHIS SHELBY COUNTY SCHOOLS

New Retiree Health Care Plan
Enrollment/Change Form
(Please complete this form in its entirety)

Administered by
Connecticut General Life Insurance Company
Cigna HealthCare of Tennessee, Inc.

A

☐ NEW RETIREE ☐ ENROLL CHANGE PERIOD	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	MSCS PLAN GROUP	CIGNA ACCOUNT NO.	BRANCH CODE
			3211484	

EMPLOYER NAME: **MEMPHIS SHELBY COUNTY SCHOOLS**
EMPLOYER ADDRESS: **160 S. HOLLYWOOD, MEMPHIS, TN 38112**

TYPE OF CHANGE:

☐ Cancel Dependent(s)* ☐ Change to Single ☐ Other _____

☐ Cancel Coverage* ☐ Change to Retiree + One Dependent

* List Names in Section B

MEDICAL COVERAGE TIER
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ WAIVE MEDICAL

PRE-65 RETIREE (under age 65)
☐ OAP IN-Network Plus ☐ OAP Basic ☐ Choice Fund HRA

POST-65 RETIREE or Medicare eligible (over age 65)
☐ MEDICARE ADVANTAGE COVERAGE ( ) PPO

DENTAL COVERAGE TIER (MUST HAVE MEDICAL COVERAGE)
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ DPPO 1500 ☐ WAIVE DENTAL

VISION COVERAGE TIER (MUST HAVE MEDICAL COVERAGE)
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ VISION ☐ WAIVE VISION

B

RETIREE NAME (Last) (First) (M.I.) SOCIAL SECURITY NO.

DATE OF BIRTH (MM/DD/CCYY) | GENDER ☐M ☐F | HOME PHONE ( ) | WORK PHONE ( ) | E-MAIL ADDRESS | PRIMARY CARE PHYSICIAN NAME | PRIMARY CARE PHYSICIAN ID

ADDRESS (Street) (City) (State) (Zip Code)

RETIREE

DEPENDENT INFORMATION Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DEPENDENT PRIMARY CARE PHYSICIAN	DATE OF BIRTH MM DD CCYY	GENDER	DEPENDENT COVERAGES	MSCS EMPLOYEE? Yes No	(check one)
Spouse		Name _____ ID _____		☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐	☐Add ☐Cancel
Dependent * Relationship		Name _____ ID _____		☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐	☐Add ☐Cancel
Dependent * Relationship		Name _____ ID _____		☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐	☐Add ☐Cancel

* **DEPENDENTS** - Up to age 26. Adult children married or unmarried and living or not living with parent qualify for this coverage. If totally disabled prior to age 26, attach proof of disability for eligibility review.

C

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐Yes ☐No *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	HIC # (MEDICARE ID NUMBER)	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

D

SIGNATURE - I have read this form and certify that all statements contained are true and correct to the best of my knowledge. I understand any material misrepresentation will result in the cancellation of my coverage and the denial of claims plus reimbursement to the health plan of any benefit payments. I understand that if my coverage contains limitations on pre-existing conditions that these limitations will be stated in the plan. I accept the provisions on the reverse side of this form which I have read and understand.

RETIREE'S SIGNATURE DATE

DISTRIBUTION: Original - Memphis Shelby County Schools **Employee**- Please make a copy for your records

(OVER)

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which maybe necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.

BASIC LIFE INSURANCE OPTIONS

We truly appreciate your many dedicated years of service!

If eligible to continue basic life insurance at retirement. Retirees can keep their current life insurance benefit amount and pay 25% percent of the monthly premium cost OR the retiree may elect a $10,000 life insurance benefit amount at no cost to the retiree – paid by MSCS.

PLEASE CHOOSE ONE AND SIGN & DATE THE BOTTOM

☐ I would like to keep my basic life insurance coverage (50% of your active coverage amount – not to exceed $50,000) & and pay 25% of the cost

☐ I would like to elect the $10,000 coverage – at no cost

☐ I am not eligible to continue basic life insurance at retirement

If elected, you will automatically be deducted from your
Tennessee Consolidated Retirement System check
(25% of the premium)

Printed Name: _____ Social#: _____

Phone Number: _____ D.O.B: _____

Signature: _____ Date: _____

Beneficiary Designation

Securian Financial Group, Inc.
Minnesota Life Insurance Company
Securian Life Insurance Company, a New York authorized insurer
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

EMPLOYER NAME: Shelby County BOE - SCS Retirees POLICY NUMBER: 34548

Insured's name (last, first, middle initial)	Last four digits of Social Security number
Address (street, city, state, zip)	

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address

This beneficiary designation applies to Retiree Basic Life coverage only.

INSTRUCTIONS:

1. Clearly print or type the information below.
2. Sign and date the completed form.
3. Return to Shelby County Schools Benefits Office: 160 S. Hollywood St., Rm 108, Memphis, TN 38112.

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

SIGNATURE REQUIRED	
Policyowner's signature X	Date

EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%

Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	5 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 56978, 651-665-7890	XXX-XX-XXXX	Brother	50%

Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Doe - Trustee, his successors or successor in trust under the John Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008.			N/A	Trust	100%

Total = 100%

Form Approved
OMB No. 0938-0787

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? ☐ Yes ☐ No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
☐☐ / ☐☐☐☐

3. Has the coverage ended? ☐ Yes ☐ 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? ☐ Yes ☐ No

2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ 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 (☐☐☐) ☐☐☐ – ☐☐☐☐

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.