U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
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Medicare Request for Employment Information

You complete Section A of this form, then ask your employer to fill out Section B.

Section A: To be completed by person signing up for Medicare Part B (Medical Insurance)

Applicant's name	Applicant's Social Security Number (SSN)
	___-___-____
Employee's name (if different from applicant)	Employee's SSN (if different)
	___-___-____
Employer's name	
Employer's address	
City / State / ZIP code	

Section B: To be completed by employer

For Employer Group Health Plans ONLY:

Is (or was) the applicant covered under an employer group health plan? ○ Yes ○ No

If yes, give the date the applicant's coverage started (mm/yyyy): __/____

Did the coverage end? ○ Yes ○ No

If yes, give the date the applicant's coverage ended (mm/yyyy): __/____

When did the employee work for your company?

From (mm/yyyy): __/____ To (mm/yyyy): __/____ Still employed? ○ Yes ○ No

If you're a large group health plan and the applicant is disabled, list all months your group health plan was primary payer.

From (mm/yyyy): __/____ To (mm/yyyy): __/____

For Hours Bank Arrangements ONLY:

Is (or was) the applicant covered under an Hours Bank Arrangement? ○ Yes ○ No

If yes, does the applicant have hours left in reserve? ○ Yes ○ No

Date reserve hours ended or will be used? (mm/yyyy) __/____

All Employers:

Signature of company official	**Date signed (mm/dd/yyyy)**
	__/__/____
Title of company official	Phone number
	(___)___-____

Submit your form by mail or fax

Mail or fax this completed form together with your Application for Enrollment in Medicare (CMS-40B) to your local Social Security office. Find an office near you at **SSA.gov/locator**.