CURRENT

RAILROAD RETIREMENT BOARD

Form Approved
OMB No. 3220-0082

RRB Claim Number
Name of Claimant
Claimant's SS No.
Name of Employee
Employee's SS No.

We need information to determine if the claimant identified above is entitled to a Special Enrollment Period for Medicare Part B (Medical Insurance) and/or entitled to premium surcharge relief for Part B premiums.

The claimant is now covered or was covered under an employer Group Health Plan based on the claimant's own or a spouse's current employment, or in the case of a disabled person, the employment of any family member. The claimant states the coverage is/was under an employer Group Health Plan for the employee identified above. The employee may be either your current or former employee.

Please answer the four items on this page and sign and date the Employer Certification. Return this page to us using the enclosed envelope. If you have any questions, please call our office at the telephone number shown above.

Sincerely,

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1. Has the claimant been covered under an employer Group Health Plan? Yes ☐ No ☐
2. Name of employer Group Health Plan: _____
3. Date of coverage under the employer Group Health Plan:

Began								Ended or Will End							
Mo.		Day		Year				Mo.		Day		Year			

4. Date the employee's employment terminated: _____

EMPLOYER CERTIFICATION

Knowing that anyone who makes a false or fraudulent statement for the purpose of obtaining benefits from the RRB is committing a crime punishable under federal law, I certify that the information is true, correct and complete.

SIGNATURE: _____

PRINT YOUR NAME: _____

PRINT YOUR TITLE: _____

TELEPHONE NUMBER: ( ) _____ DATE _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Railroad Retirement Board (RRB) is authorized to collect the information requested on this form under Sections 7(b)6 and 7(d) of the Railroad Retirement Act. The information obtained from this form will be used for determining whether the claimant applying for Part B under Medicare may be entitled to a Special Enrollment Period and/or premium surcharge relief because of coverage under an employer Group Health Plan. Although you are not required to furnish this information, if you fail to do so, the claimant may not be considered eligible by the RRB to receive these benefits.

We estimate this form takes an average of 10 minutes per response to complete, including the time for reviewing the instructions, obtaining the data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate, or any other aspect of this form, including suggestions for reducing completion time, to the Chief of Information Resources Management, Railroad Retirement Board, 844 N. Rush St., Chicago, IL 60611-2092.