Form Approved
OMB No. 0938-0769 (Expires: TBD)

REQUEST FOR RETIREMENT BENEFIT INFORMATION

Employee's Name	Employee's Social Security Number

Employer's Name

Employer's Address

Claimant's Name	Claimant's Social Security Number

We need the information listed below in connection with _____
(claimant's name)

1. Is the claimant receiving retirement payments based on his/her own State or local government employment? ❑ YES ❑ NO

2. Is the claimant the spouse, divorced spouse, widow or widower of a person who is receiving (or did receive) retirement payments based on his/her own State or local government employment? ❑ YES ❑ NO

3. How long did the claimant (or spouse) work for the State or local government employer?

Beginning Date	Last Date of Employment

4. Has the pension plan or former employer subsidized the claimant's Medicare Part A premium in whole or in Part for any month during the past 7 years? ❑ YES ❑ NO

5. If the claimant is found to be eligible for the reduced Medicare Part A premium, will his/her retirement payments be adjusted or recalculated? ❑ YES ❑ NO

I certify that the statements given above are true. I know that anyone who makes a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law.

Signature of Official	Title of Official

Telephone Number	Date