

REQUEST FOR RETIREMENT BENEFIT INFORMATION

Employee's Name	Employee's Social Security Number
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Employer's Name

Employer's Address

Claimant's Name	Claimant's Social Security Number
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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
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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

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 collection is 0938-0769. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.