Form Approved
OMB No. 0938-0769
Expires: xx/xx

Medicare Request for Retirement Benefit Information

Use this form to request a Medicare Part A (Hospital Insurance) premium reduction based on your employment by a state or local government.

How to submit this form

Mail, fax, or take your completed form to your local Social Security office. Find an office near you at **SSA.gov/locator**.

Get help with this form

- **Phone:** Call Social Security at **1-800-772-1213**. TTY users can call 1-800-325-0778.
- **En Español:** Llame a SSA gratis al **1-800-772-1213** y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- **In-person:** Visit your local Social Security office for in-person help. Find an office near you at **SSA.gov/locator**.

Get information in another format

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

PRA Disclosure Statement: 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 0938-0769. 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.

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

Section A: To be completed by the person requesting a Medicare Part A premium reduction

1. Employee name		2. Employee Social Security Number
3. Employer name		
4. Employer address		
City	State	ZIP code
5. Claimant name (if different from the employee's name)		6. Claimant Social Security Number

Section B: To be completed by employer

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) .... ◯ Yes ◯ No
   retirement payments based on his/her own state or local government employment?

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

Beginning date (mm/yyyy)	Last date of employment (mm/yyyy)

4. Has the pension plan or former employer subsidized the claimant's Medicare Part A premium in whole or in .... ◯ Yes ◯ No
   part for any month during the past 7 years?

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

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 agency official	Title of agency official
Phone number	Date signed (mm/dd/yyyy)