DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

# REQUEST FOR EMPLOYMENT INFORMATION

Form Approved OMB No. 0938-0787

Expires: 10/2024

## WHAT IS THE PURPOSE OF THIS FORM?

In order to apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse’s current employment. People with disabilities must have large group health plan coverage based on your, your spouse’s or a family member’s current employment.

This form is used for proof of group health care coverage based on current employment. This information is needed to process your Medicare enrollment application.

The employer that provides the group health plan coverage completes the information about your health care coverage and dates of employment.

## HOW IS THE FORM COMPLETED?

* Complete the first section of the form so that the employer can find and complete the information about your coverage and the employment of the person through which you have that health coverage.
* The employer fills in the information in the second section and signs at the bottom.

## WHAT DO I DO WITH THE FORM?

Fill out Section A and take the form to your employer. Ask your employer to fill out Section B. You need to get the completed form from your employer and include it with your Application for Enrollment in Medicare (CMS-40B). Then you send both together to your local Social Security office. Find your local office here: [**www.ssa.gov**.](http://www.ssa.gov/)

## GET HELP WITH THIS FORM

* **Phone:** Call Social Security at **1-800-772-1213**
* **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:** Your local Social Security office. For an office near you check [**www.ssa.gov**.](http://www.ssa.gov/)

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Medicare Request for Employment Information

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State Health Insurance Assistance Program (SHIP): Visit shiphelp.org to get free, personalized, and unbiased health insurance counseling from your local SHIP.

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Use this form to show proof of group health plan coverage based on current employment so you can enroll in Medicare. You complete Section A of this form, then ask your employer to fill out Section B.

To enroll in Medicare through a Special Enrollment Period, you must have had group health plan coverage through your or your spouse’s current employment since the first month you were eligible for Medicare Part B. Your coverage must not have ended more than 8 months ago. If you qualify for Medicare because of a disability, you must have large group health plan coverage based on your, your spouse’s or a family member’s current employment.

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*2024-08-26 14:57:09*

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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.

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*2024-08-26 15:03:38*

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This statement is moved up further on page one on the redesigned form.

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This form will only be known as CMS-L564 going forward. It's known as the CMS-L564 internally and externally. It will no longer be CMS-L564 AND CMS-R-297.

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Privacy Act Statement:

Social Security is authorized to collect your information under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii) for your enrollment in Medicare Part B. Social Security and the Centers for Medicare & Medicaid Services (CMS) need your information to determine if you’re entitled to Part B. While you don’t have to give your information, failure to give all or part of the information requested on this form could delay your application for enrollment. Social Security and CMS will use your information to enroll you in Part B. Your information may be also be used to administer Social Security or CMS programs or other programs that coordinate with Social Security or CMS to: 1) Determine your rights to Social Security benefits and/or Medicare coverage. 2) Comply with Federal laws requiring Social Security and CMS records (like to the Government Accountability Office and the Veterans Administration). 3) Assist with research and audit activities necessary to protect integrity and improve Social Security and CMS programs (like to the Bureau of the Census and contractors of Social Security and CMS). We may verify your information using computer matches that help administer Social Security and CMS programs in accordance with the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503). Paperwork Reduction Act:

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 0938-0787. The time required to complete this information 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Important: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren’t about how to improve this form or its collection burden (outlined in OMB 0939-0251) will be destroyed. It will not be kept, reviewed, or forwarded to Social Security or any other agency.

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 <https://www.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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

# REQUEST FOR EMPLOYMENT INFORMATION

### SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer’s Name

2. Date

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3. Employer’s Address

City State Zip Code

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Form Approved OMB No. 0938-0787

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| 4. | Applicant’s Name | 5. Applicant’s Social Security Number | | | |
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| 6. | Employee’s Name | 7. Employee’s Social Security Number | | | |
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### SECTION B: To be completed by Employers For Employer Group Health Plans ONLY:

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

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1. If yes, give the date the applicant’s coverage began. (mm/yyyy)

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1. Has the coverage ended?  Yes  No

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1. If yes, give the date the coverage ended. (mm/yyyy)

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1. When did the employee work for your company?

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| From: (mm/yyyy)  / | To: (mm/yyyy) | | | Still Employed: (mm/yyyy) | | |
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1. If you’re a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.

From: (mm/yyyy)

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To: (mm/yyyy)

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The Paperwork Reduction Act statement is moved to page 1 on the redesigned form.

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*2024-08-26 15:11:39*

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Medicare Request for Employment Information

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*2024-08-26 15:12:44*

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

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*2024-08-26 15:14:41*

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employer

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*2024-08-26 15:15:25*

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started

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*2024-08-26 15:17:13*

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Did the coverage end?

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If yes, give the date the applicant's coverage ended.

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*2024-08-26 15:20:55*

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Still employed? Yes No

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*2024-08-26 17:58:49*

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If yes, does the applicant have hours left in reserve?

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*2024-08-26 18:03:29*

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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.

### For Hours Bank Arrangements ONLY:

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1. Is (or was) the applicant covered under an Hours Bank Arrangement?  Yes  No
2. If yes, does the applicant have hours remaining in reserve?  Yes  No
3. Date reserve hours ended or will be used? (mm/yyyy)

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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 0938-0787. The time required to complete this information

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| **All Employers:** |  |  | | | | |
| Signature of Company Official | Date Signed |
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| Title of Company Official | Phone Number |  |  |  |  |  |
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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.

# STEP BY STEP INSTRUCTIONS FOR THIS FORM

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## SECTION A:

### The person applying for Medicare completes all of Section A.

1. **Employer’s name:**

Write the name of your employer.

1. **Date:**

Write the date that you’re filling out the Request for Employment Information form.

1. **Employer’s address:**

Write your employer’s address.

1. **Applicant’s Name:**

Write your name here.

1. **Applicant’s Social Security Number:**

Write your Social Security Number here.

1. **Employee’s Name:**

If you get group health plan coverage based on your employment, write your name here. If you get group health plan coverage through another person, like a spouse or family member, write their name.

1. **Employee’s Social Security Number:**

If you get group health plan coverage based on your employment, write your Social Security Number here. If you get group health plan coverage through another person, like a spouse or family member, write their Social Security Number.

### Once you complete Section A:

Once Section A is completed, give this form to your employer to complete Section B. Once Section B has been completed

by your employer, return this form along with your Part B application to your local Social Security office.

## SECTION B:

### The employer completes all of Section B.

**If you’re an employer without an hours bank arrangement, complete the section called “For Employer Group Health Plans ONLY”**

1. **Is (or was) the applicant covered under an employer group health plan?**

Please check yes or no if the applicant was covered under your group health plan offered by your company. The applicant may be the employee or another person related to the employee, such as a spouse or family member with disabilities. If your company doesn’t offer a group health plan, please check No. A group health plan is any plan

of one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or their families.

1. **If yes, give the date the coverage began.**

Write the month and year the date the applicant’s coverage began in your group health plan.

1. **Has the coverage ended?**

Check yes or no if the group health plan coverage for the applicant has ended.

1. **If yes, give the date the coverage ended.**

Write the month and year the group health plan coverage ended for the applicant.

1. **When did the employee work for your company?**

Write the start and end dates of the employment for the employee in which the applicant is related. It may be the applicant or another person related to the employee, such as a spouse or family member with disabilities.

Enter the month and year of the start of the employment in the “From” box.

Enter the month and year of end of the employment in the “To” box.

If the employee is still employed, enter the month and year of the current date.

Current employment is active working status. It is not disability or retirement.

1. **If you’re a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.**

Write the start and end dates that your group health plan was primary payer for the applicant.

### If you’re an employer with an hours bank arrangement, complete the section called “For Hours Bank Arrangements ONLY”

1. **Is (or was) the applicant covered under an hours bank arrangement?**

Please check yes or no if the applicant was covered under an hours bank arrangement. If you check no, please also fill out the section for “Employer Group Health Plans ONLY”.

1. **If yes, does the applicant have hours remaining in reserve?**

Please indicate if the applicant currently has health coverage based on the remaining hours in the employee’s hours bank account.

1. **Date reserve hours ended or will be used?**

Please write the month and year for when the remaining hours in the employee’s hours bank account expired or will expire.

### All employers need to complete the bottom of Section B.

* + **Signature of Company Official:**

An official representative of the company needs to sign this document. Please do not print.

* + **Date Signed:**

Write the date that you sign the form in this field.

* + **Title of Company Official:**

Print the title of the company official who signed the form in this field.

* + **Phone Number:**

Write the phone number of the company official who signed the form in this field. If there are questions regarding the information on this form, a representative from Social Security will contact you.

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*2024-08-27 12:09:24*

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Per the Office of Communication's language suggestion, step-by-step instructions are removed fro the redesigned form.