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

Form Approved OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

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 W

Fill out Section A an
Ask your employer t
the completed form
with your Applicatio
40B). Then you send
Security office. Find
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
office near you ch

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Medicare Request for Employment Information

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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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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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 &

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This form will be known as CMS-L564 going forward instead of the CMS-L564 and CMS-R-297.

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.

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Form Approved OMB No. 0938-0787

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

/ /

3. Employer's Address

City State Zip Code

4. Applicant's Name

5. A

6. Employee's Name

7. E

SECTION B: To be completed by

Employers For Employer Group

Health Plans ONLY:

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

2. If yes, give the date the applicant's coverage b[illegible]. (mm/yyyy)

/

3. Has the coverage ende[illegible] ☐ Yes ☐ No

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

/

5. When did the employee work for your company?

From: (mm/yyyy) / To: (mm/yyyy) / St

6. If you're a large group health plan and the applicant is disabled, please list the timeframe plan was primary payer.

From: (mm/yyyy) / To: (mm/yyyy) /

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☐ N

2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No

3. Date reserve hours ended or will be used? (mm/yyyy)

/

All Employers:

Signature of Company Official

Date Signed / /

Title of Company Official

Phone Number ( ) -

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a c[illegible] displays a valid OMB control number. The valid OMB control number for this information is 09[illegible] 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, Baltim[illegible] MD 21244-1850.

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Medicare Request for Employment Information
You complete Section A of this form, then ask your employer to fill out Section B.

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employer

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started

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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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Still employed? Yes No

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

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Submit your completed form with your Application for Enrollment in Medicare (CMS-40B) to your local Social Security office. Find an office near you at SSA.gov/locator.

STEP BY STEP INSTRUCTIONS FOR THIS FORM

SECTION A:
The person applying for Medicare completes all of Section A.

1. Employer's name:
Write the name of your employer.

2. Date:
Write the date that you're filling out the Request for Employment Information form.

3. Employer's address:
Write your employer's address.

4. Applicant's Name:
Write your name here.

5. Applicant's Social Security Number:
Write your Social Security Number here.

6. 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.

7. 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.

2. 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.

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

4. If yes, give the date the coverage ended.
Write the month and year the group health plan coverage ended for the applicant.

5. **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.
6. **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”
2. **If yes, does th… remaining in re…**
   Please indicate if … coverage based o… employee’s hours …
3. **Date reserve h… ended or will be used?**
   Please write the … remaining hours in the employee’s hours bank account expired or will expire.

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

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.