



RAILROAD RETIREMENT BOARD

<OFFICE NAME>

<OFFICE ADDRESS>

<OFFICE CITY, STATE, ZIP CODE>

WWW.RRB.GOV

FORM APPROVED
OMB No. 3220-0082

PROPOSED

OFFICE HOURS: M-F 9:00 AM TO 3:00 PM
CLOSED FEDERAL HOLIDAYS

TOLL-FREE NUMBER: 1-877-772-5772

RRB Claim Number:

Name of Claimant:

Claimant's SS No.:

To help us determine if **<Beneficiary's Name>** is eligible to enroll in a Special Enrollment Period for **Medicare Medical Insurance (Part B)** and/or premium surcharge relief for Part B premiums, please answer the items **below and return this page to us using the enclosed envelope.**

If you have any questions, please call the telephone number shown above.

Sincerely,

Enclosure: Envelope

EVIDENCE OF COVERAGE UNDER AN EMPLOYER GROUP HEALTH PLAN										
1. Is (or was) <Beneficiary's Name> covered under an employer Group Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No										
2. If yes, provide the date the applicant's coverage began. *Note: If your company has changed healthcare providers during the beneficiary's employment, please include earliest date of coverage. _____ / _____ Month Year										
3. Has the coverage ended? <input type="checkbox"/> Yes <input type="checkbox"/> No										
4. If yes, provide the date the applicant's coverage ended. _____ / _____ Month Year _____ / _____ Month Year										
5. When did the employee work for your company? (See below for additional information) <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 33%;">From</td> <td style="text-align: center; width: 33%;">To</td> <td style="text-align: center; width: 33%;">Still Employed</td> </tr> <tr> <td style="text-align: center;">_____ / _____</td> <td style="text-align: center;">_____ / _____</td> <td style="text-align: center;">_____ / _____</td> </tr> <tr> <td style="text-align: center;">Month Year</td> <td style="text-align: center;">Month Year</td> <td style="text-align: center;">Month Year</td> </tr> </table>		From	To	Still Employed	_____ / _____	_____ / _____	_____ / _____	Month Year	Month Year	Month Year
From	To	Still Employed								
_____ / _____	_____ / _____	_____ / _____								
Month Year	Month Year	Month Year								
6. Attestation - I understand that anyone who, knowingly and willfully — (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined or imprisoned not more than 5 years, or both.										
Signature										
Print Your Name and Title										
Telephone Number ()	Date									

Further explanation for question 5.

In general, an individual has “current employment status” if they are **actively working** as an employee, are the employer (including a self- employed individual), or are associated with the employer in a business relationship.

An individual also has “current employment status” if they are **not actively working, but meets all of the following conditions:**

- retains employment rights in the industry;

- employment has not been terminated by the employer (if the employer provides the coverage); or membership in the employee organization has not been terminated (if the employee organization provides the coverage);
- is not receiving disability benefits from an employer for more than 6 months.

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

The Railroad Retirement Board (RRB) is authorized to collect the information requested on this form under Sections 7(b)6 and 7(d) of the Railroad Retirement Act. The information obtained from this form will be used for determining whether the claimant applying for Part B under Medicare may be entitled to a Special Enrollment Period and/or premium surcharge relief because of coverage under an employer Group Health Plan. Although you are not required to furnish this information, if you fail to do so, the claimant may not be considered eligible by the RRB to receive these benefits.

We estimate this form takes an average of 10 minutes per response to complete, including the time for reviewing the instructions, obtaining the data, and reviewing the completed form. If you wish, send comments regarding the accuracy of our estimate, or any other aspect of this form, including suggestions for reducing completion time, to: Railroad Retirement Board, ATTN: Bureau of Information Services/Policy & Compliance, 844 N. Rush St., Chicago, IL 60611-1275.