

PERS08M0021DMC (06/2004)

## **Certification of Medicare Status**

Please complete **Section 1**, <u>and</u> either **Section 2**, **3 or 4**. Sign and date the form and return it to CalPERS at address listed below. Please complete this form for each Medicare-eligible participant.

Section 1: Please enter the Member's/Dependent's name and Social Security Number	
CalPERS Retiree Name:	CalPERS Retiree Social Security Number:
Member/Dependent Age 65 or older:	Member/Dependent Social Security Number:
	I in Medicare Parts A and B are Part B. This is the information reflected on my reditlement from the Social Security Administration:
Name of Medicare Beneficiary	
Medicare Claim Number	
HOSPITAL (PART A) effective date	
MEDICAL (PART B) effective date	
<ul> <li>Check all boxes that apply to you.)</li> <li>☐ I did not work for any Social Security covered employee</li> <li>☐ I worked for Social Security covered employee</li> </ul>	
_	deceased) that qualifies me for Medicare Part A.
	ks and has Employer Group Health Plan coverage due to working beyond age 65 and have coverage in and have attached documentation of this fact.
Name of your current employer	
2. Name of your Group Health Plan provided by	by your employer
Under penalty of perjury, I certify that the above	e information is true and complete.
Signature Signature Signature	 Date
()	
P.C Sacramer	Account Services D. Box 942714 nto, CA 94229-2714 calPERS 225-7377