

GROUP VERIFICATION OF MEDICARE COVERAGE FOR WORKERS AGED 65 AND OVER

A. FEDERAL REQUIREMENT

Federal Law requires employers with 20 or more employees to offer the same coverage to their employees and spouses who are age 65 or older they offer to younger employees and spouses. These enrollees' coverage must be primary to Medicare. Employers must comply with the requirement if the employer has 20 or more actively working full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. Self-employed individuals who participate in an employer plan are not counted as employees for purposes of determining if the minimum size requirement is met. When an employer did not have 20 or more employees in the preceding year, it would only be required to offer its employees and spouses age 65 and over primary coverage in the event that the employer employs 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer coverage that is primary to Medicare for the remainder of that calendar year and throughout the following calendar year, even if the number of employees drops below 20 after the employer has met the requirement. Employers who do not meet this requirement are not required to provide primary coverage to their age 65 or over employees or spouses.

I hereby certify that **less than** 20 actively working full-time and/or part-time employees were employed for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. I also certify that all full and part-time employees have been counted, regardless of whether they were actually at work on every day in the period or whether they were enrolled in the group plan. As a result of this count, this employer is not required to provide coverage primary to Medicare for employees or spouses who are 65 or older.

B. EMPLOYEE ROSTER

The following actively working employees are aged 65 or older and currently have Medicare Parts A and B as Primary Coverage:

Note: Attach additional pages as necessary.

1. Employee Name (please print) _____ Date of Birth / / _____
Social Security Number _____
Employee Signature _____
2. Employee Name (please print) _____ Date of Birth / / _____
Social Security Number _____
Employee Signature _____
3. Employee Name (please print) _____ Date of Birth / / _____
Social Security Number _____
Employee Signature _____
4. Employee Name (please print) _____ Date of Birth / / _____
Social Security Number _____
Employee Signature _____

C. CERTIFICATION

I understand that we, the employer, are solely responsible to keep count of employees for the purpose of these Medicare secondary payer rules and to notify Premera Blue Cross immediately of any changes. I certify that this certification and the attached information (if applicable) are complete and accurate and agree to provide Premera with such information and documentation as it may reasonably request to verify active employment and Medicare coverage.

Group Name _____ Group Number _____
Group Administrator Name (please print) _____ Date / / _____
Group Administrator Signature _____