Getting Medicare when you retire

If you (or your spouse) are getting ready to retire, or if you lose your job-based health insurance before you stop working, you have a limited time to sign up for Medicare without penalty. You may want to start thinking about signing up for Medicare a few months before you retire.

5 things to do before signing up for Medicare

1. **Ask the employer or benefits administrator how its retiree coverage works with Medicare.** You'll want to know if your (or your family's) current benefits will change, if they offer retirement coverage or other supplemental coverage that works with Medicare, and if any drug coverage they offer is creditable drug coverage. Get questions to ask.
2. **Check when your current coverage ends and sign up for Medicare about a month earlier.** Signing up for Medicare before your current coverage ends can help you avoid a gap in coverage.
3. **Ask the employer to fill out the employment form.** You'll need this extra form to qualify for a Special Enrollment Period to sign up without penalty.
4. **Find Medicare plans in your area,** if you don't have retiree coverage or if the employer doesn't offer creditable drug coverage. If you join a Medicare Advantage Plan or Medicare drug plan, coverage starts the first day of the next month.
5. **To avoid a tax penalty, you and your employer should stop contributing to your Health Savings Account (HSA) (if you have one) 6 months before you retire** or apply for benefits from Social Security (or the Railroad Retirement Board).
   Why should I stop contributions before I retire?

When & how do I sign up for Medicare?

You can sign up anytime while you (or your spouse) are still working **and** you have health insurance through that employer. You also have 8 months after you (or your spouse) stop working to sign up.

- Your 8-month Special Enrollment Period starts when you stop working, even if you choose COBRA or other coverage that's not Medicare.
- Your coverage will start the month after Social Security (or the Railroad Retirement Board) gets your completed forms.

You'll need to have your employer fill out a Form CMS-L564 (Request for Employment Information). If the employer can't fill it out, complete Section B of the form as best you can, but don't sign it. You'll need to submit proof of job-based health insurance when you sign up.
What forms of proof can I send?

The way you sign up depends on if you already have Part A coverage or if you're signing up for both Part A and Part B. Get forms and ways to sign up.

> **Avoid the penalty & gap in coverage**
> If you miss this 8-month Special Enrollment Period, you'll have to wait to sign up and go months without coverage. You might also pay a monthly penalty for as long as you have Part B. The penalty goes up the longer you wait to sign up.
> How much is the Part B penalty?

Feedback

What do you want to do next?

- Next Step: Discover ways to sign up
- Take Action: Find plans & Medigap policies
- More Details: Learn more about retiree insurance

Ready to sign up for Part A & Part B

To sign up for Part A (Hospital Insurance) and/or Part B (Medical Insurance), you'll need to contact the Social Security Administration. Depending on your situation, we can help you find the easiest way to sign up.

Why don't I contact Medicare to sign up for Part A and Part B?

What's your situation?

I want to sign up for both Part A & Part B or only Part A when I turn 65

1. Apply online (at Social Security) – This is the easiest and fastest way to sign up and get any financial help you qualify for.
2. You'll create your secure *my* Social Security account to sign up for Medicare or apply for Social Security benefits online.

> You can only sign up for Part B (or Part A if you have to pay a premium for it) at certain times. Learn about Part A & Part B sign up periods.

Apply Online

I already have Part A & want to add Part B because I'm losing my job-based coverage

1. Apply online to sign up for Part B if you already have Part A.
2. Have the employer fill out form CMS-L564.
3. Send the completed form to your local Social Security office by fax or mail.

> If the employer can't fill it out, complete Section B of the CMS-L564 form as best you can, but don't sign it. You'll need to submit proof of job-based health insurance. Learn about what forms of proof you'll need to send.

Apply Online

I want to sign up for Part A & Part B, but I missed my chance when I turned 65

> You can only sign up using one of these Special Enrollment Periods in certain situations.
> What situations qualify for an exceptional conditions Special Enrollment Period?

1. Fill out form CMS-10797.
2. Send the completed form to your local Social Security office by fax or mail.

Download Form

Feedback

I have Part A already & want to add Part B (only

available Jan 1 – March 31)

Only sign up this way if none of the other situations on this page apply to you. You can only sign up for Part B at certain times. Learn about Part A & Part B sign up periods.

1. Fill out form CMS-40B.
2. Send the completed form to your local Social Security office by fax or mail.

Download Form

Contact Social Security to submit your forms or get help:

- Send completed forms to your local Social Security office by fax or mail.
- Call 1-800-772-1213. TTY users can call 1-800-325-0778.
- Contact your local Social Security office.
- If you or your spouse worked for a railroad, call the Railroad Retirement Board at 1-877-772-5772.

If you live outside the U.S.: You may want to get Part B if you plan to return to the U.S. to get health care services. Get help signing up for Part B if you live in a foreign country.

Feedback

After you sign up

You'll get a welcome package with your Medicare card, which has your Medicare Number. You'll need your Medicare Number to create your secure Medicare account here on Medicare.gov, join a plan, or buy supplemental insurance.

What do you want to do next?

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

Form Approved
OMB No. 0938-1230
Expires: 01/25

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

WHO CAN USE THIS APPLICATION?

People with Medicare who have Part A(hospital insurance) but not Part B

NOTE: If you do **not** have Part A, do **not** complete this form. Contact Social Security if you want to apply for Medicare for the first time.

WHEN DO YOU USE THIS APPLICATION?

Use this form:

- If you're in your **IEP** and **refused Part B** or did not sign up when you applied for Medicare, but now want Part B.
- If you want to sign up for Part B during the General Enrollment Period (GEP) from January 1 – March 31 each year.
- If you're eligible for a Special Enrollment Period (SEP).
- If you're in your **Initial Enrollment Period** (IEP) and live in **Puerto Rico.** You must sign up for Part B using this form.

NOTE: Your IEP lasts for 7 months. It begins 3 months before your 65th birthday (or 25th month of disability) and ends 3 months after you reach 65 (or 3 months after the 25th month of disability).

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS APPLICATION?

You will need:

- Your Medicare Number
- Your current address and phone number

WHAT HAPPENS NEXT?

Send your completed and signed application to your local Social Security office. If you have questions, call Social Security at **1-800-772-1213. TTY users should call 1-800-325-0778.**

HOW DO YOU GET HELP WITH THIS APPLICATION?

- **Phone:** Call Social Security at **1-800-772-1213. TTY users should call 1-800-325-0778.**
- **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 **ssa.gov/locator**.

REMINDERS

- If you sign up for Part B, you must pay premiums for every month you have the coverage.
- If you sign up after your IEP, you may have to pay a late enrollment penalty (LEP) of 10% for each full 12-month period you don't have Part B but were eligible to sign up. You may have to pay this LEP as long as you have Part B coverage.
- If you do not enroll in Part B during your IEP or GEP, you may be eligible for a Special Enrollment Period (SEP). Please see page 3 for more information.

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 **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.

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 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).

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 0938-1230. 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. As authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repaying of incorrect or delinquent debts under these programs.

Form Approved
OMB No. 0938-1230
Expires: 01/25

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number
   ☐☐☐☐ – ☐☐☐ – ☐☐☐☐

2. Your Name (Last Name, First Name, Middle Name)

3. Mailing Address (Number and Street, PO Box, or Route)

4. City | State ☐☐ | Zip Code ☐☐☐☐☐

5. Phone Number (Including Area Code) (☐☐☐) ☐☐☐ – ☐☐☐☐

6. Do you wish to sign up for Medicare Part B (Medical Insurance)? ☐ YES

7a. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete 7c.) ☐ YES ☐ NO

7b. Are you currently (or were you) an international volunteer for a non-profit organization and have or had health coverage provided to you? (If yes, complete 7c.) ☐ YES ☐ NO

7c. Enter dates of employment (or volunteer work) and health coverage below. (Enter all dates as MM/YYYY)

Dates you (or your spouse) worked for employer that provided health coverage:	Dates of health coverage from employer (or non-profit organization):	Dates you worked as a volunteer outside the U.S.:
Start Date: ☐☐/☐☐☐☐	Start Date: ☐☐/☐☐☐☐	Start Date: ☐☐/☐☐☐☐
Ending Date: ☐☐/☐☐☐☐	Ending Date: ☐☐/☐☐☐☐	Ending Date: ☐☐/☐☐☐☐
Not ended ☐	Not ended ☐	Not ended ☐

8. Has an employer, health insurance provider, or other entity requested or required you to enroll in Part B? (If yes, explain how and why in the Remarks section, and include proof or documentation with this form.) ☐ YES ☐ NO

9. Remarks:

10. Written Signature (DO NOT PRINT)
SIGN HERE

11. Date Signed ☐☐/☐☐/☐☐☐☐

IF THIS APPLICATION HAS BEEN SIGNED WITH A MARK OR AN (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

12. Signature of Witness

13. Date Signed ☐☐/☐☐/☐☐☐☐

14. Address of Witness (Street Number and Name, City, State, Zip)

Form Approved
OMB No. 0938-1230
Expires: 01/25

SPECIAL MESSAGE FOR INDIVIDUAL APPLYING FOR PART B

This form is your application for Medicare Part B (Medical Insurance). You can use this form to sign up for Part B:

- During your Initial Enrollment Period (IEP) when you're first eligible for Medicare
- During the General Enrollment Period (GEP) from January 1 through March 31 of each year
- If you're eligible for a Special Enrollment Period (SEP).

Initial Enrollment Period

Your IEP is the first chance you have to sign up for Part B. It lasts for 7 months. It begins 3 months before the month you reach 65, and it ends 3 months after you reach 65. If you have Medicare due to disability, your IEP begins 3 months before the 25th month of getting Social Security Disability benefits, and it ends 3 months after the 25th month of getting Social Security Disability benefits. To have Part B coverage start the month you're 65 (or the 25th month of disability insurance benefits); you must sign up in the first 3 months of your IEP. If you sign up in any of the remaining 4 months, your Part B coverage will start later.

General Enrollment Period

If you don't sign up for Part B during your IEP, you can sign up during the GEP. The GEP runs from January 1 through March 31 of each year. If you sign up during a GEP, your Part B coverage begins the month after you sign up. You may have to pay a late enrollment penalty if you sign up during the GEP. The cost of your Part B premium will go up 10% for each 12-month period that you could have had Part B but didn't sign up. You may have to pay this late enrollment penalty as long as you have Part B coverage.

Special Enrollment Period

If you don't sign up for Part B during your IEP, you can sign up without a late enrollment penalty during a Special Enrollment Period (SEP). You can use a SEP when your IEP has ended. The most common SEPs apply to the working aged, disabled, and international volunteers. If you think that you may be eligible for a SEP, please contact Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

SEP for Exceptional Conditions

If, due to an exceptional condition, you didn't sign up for Medicare Premium Part A or Part B during your IEP, GEP, or a SEP, you can sign up during a SEP for Exceptional Conditions. If you think that you may be eligible for a SEP for Exceptional Conditions, please complete the form CMS 10797 (Application for Medicare Part A and Part B Special Enrollment Period (Exceptional Circumstances)). Visit **cms.gov/medicare/cms-forms/cms-forms/cms-forms-list/cms10797**

Working Aged/Disabled

You have a SEP if you're covered under a group health plan (GHP) based on *current* employment. To use this SEP, you must:

- Be 65 or older and currently employed.
- Be the spouse of an employed person, and covered under your spouse's employer GHP based on his/her current employment.
- Be under 65 and disabled, and covered under a GHP based on your own or your spouse's current employment.

You can sign up for Part B anytime while you have a GHP coverage based on current employment or during the 8 months after either the coverage ends or the employment ends, whichever happens first. If you sign up while you have GHP coverage based on current employment, or, during the first full month that you no longer have this coverage, your Part B coverage will begin the first day of the month you sign up. You can also choose to have your coverage begin with any of the following 3 months. If you sign up during any of the remaining 7 months of your SEP, your Part B coverage will begin the month after you sign up.

In addition to this application, you will also need to have your employer fill out and return the "Request for Employment Information" form (**CMS-L564**) with your application.

NOTE: COBRA coverage or a retiree health plan is not considered group health plan coverage based on current employment.

International Volunteers

You have a SEP if you were volunteering outside of the United States for at least 12 months for a tax-exempt organization and had health insurance (through the organization) that provided coverage for the duration of the volunteer service.

Form Approved
OMB No. 0938-1230
Expires: 01/25

STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS APPLICATION

1. **Your Medicare Number:**
Write your Medicare number.

2. **Name:**
Write your name as you did when you applied for Social Security or Medicare. List last name, first name and middle name in that order. If you don't have a middle name, leave it blank.

3. **Mailing Address:**
Write your full mailing address including the number and street name, PO Box, or route in this field.

4. **City, State, and ZIP code:**
Write the city name, state, and ZIP code for the mailing address.

5. **Phone Number:**
Write your 10-digit phone number, including area code.

6. **Do you wish to sign up for Medicare Part B (Medical Insurance)?**
Mark "YES" in this field if you want to sign up for Medicare Part B which provides you with medical insurance under Medicare. You can only sign up using this form if you already have Medicare Part A (Hospital Insurance). If your answer to this question is "NO" then you don't need to fill out this application. This application is to sign up to get medical insurance under Medicare.

   If you don't have Part A and want to sign up, please contact Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

7a. **Do you currently have (or did you have) coverage through an employer or union group health plan? Select one:** YES or NO. A group health plan is generally a health plan offered by an employer or employee organization that provides health coverage to employees and their families. If you select YES, complete item 7c.

7b. **Are you currently (or were you) an international volunteer for a non-profit organization and also have health coverage by that organization? Select one:** YES or NO. For more information about international volunteers see the note on page 2. If you select YES, complete item 7c.

7c. **Enter dates of employment (or volunteer work) and health coverage:** Only complete this item if you selected YES to item 7a or 7b. You only need to enter any work and health coverage you had since you turned 65. If you selected YES to item 7a, enter information about your (or your spouse's) employer health coverage. You need to list both the dates you (or your spouse) worked for the employer that provided your health coverage in the first column in the chart, and the dates you had health coverage in the second column in the chart.

(7c. continued)
If you selected YES to item 7b, enter information about your health coverage while you were volunteering outside the U.S. You need to list both the dates you volunteered for the non-profit organization that provided your health coverage in the third column in the chart, and the dates you had health coverage in the second column in the chart. Enter both the start and end dates for each item. If it hasn't ended yet, select "NOT ENDED." Enter all dates as MM/YYYY. If you need more space, add the information in the Remarks section of question 9.

8. **Do you currently have (or had) an employer or entity that has requested (or requires) you to enroll into Part B?**
Select one: YES or NO. If you selected YES, indicate it in remarks section of question 9. Send documentation with this form.

9. **Remarks:**
Provide any remarks or comments on the form to clarify information about your enrollment application.

10. **Written Signature:**
Sign your name in this section in the same way you would sign it for any other official document. Do not print.
If you're unable to sign, you may mark an "X" in this field. In this case, you will need a witness and the witness must complete questions 12, 13 and 14.

11. **Date Signed:**
Write the date that you signed the application.

12. **Signature of Witness:**
In the case that question 10 is signed by an "X" instead of a written signature, a witness signature is needed showing that the person who signs the application is the person represented on the application.

13. **Date Signed:**
If a witness signs this application, the witness must provide the date of the signature.

14. **Address of Witness:**
If a witness signs this application, provide the witness's address.

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

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Expires: 10/2024

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 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**.

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**.

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. Applicant's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

6. Employee's Name

7. Employee's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

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 began. (mm/yyyy)
☐☐ / ☐☐☐☐

3. Has the coverage ended? ☐ 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) ☐☐ / ☐☐☐☐

Still Employed: (mm/yyyy) ☐☐ / ☐☐☐☐

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.

From: (mm/yyyy) ☐☐ / ☐☐☐☐

To: (mm/yyyy) ☐☐ / ☐☐☐☐

For Hours Bank Arrangements ONLY:

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)
☐☐ / ☐☐☐☐

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 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 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

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 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.
3. **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.