

Section IV

I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Subscriber Name

Subscriber's Plan ID

Name of Person Completing This form (Please Print)

Signature of Person Completing This Form

Date

If you have completed Sections I-IV above, stop here. If you are refusing to provide the information requested in Sections I-IV, proceed to Section V.

Section V

Subscriber Name (Please Print)

Subscriber's Plan ID

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form

Date