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

Form Approved
OMB No. 0938-0787

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.

Form CMS-L564 (CMS-R-297) (0 9/1 6)