MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lieutenant Governor

DAVID R. BRINKLEY
Secretary

STATE NOTIFICATION OF MEDICARE INFORMATION

PLEASE COMPLETE THIS FORM and return to:

Employee Benefits Division
301 W. Preston Street, Room 510
Baltimore, Maryland 21201

Retiree's Name: _____ Social Security #: _____-_____-_____

Address: _____ City, State, And Zip: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

IMPORTANT: In accordance with Federal and State regulations, an individual must be placed in coverage that is supplemental to Medicare Parts A and B as soon as both of the following criteria are met: (1) medical insurance is under a retiree group health plan, and (2) Medicare entitlement exists either by having reached age 65 or by having a total permanent disability acknowledged by Social Security at any age.

Medicare becomes the primary insurer as soon as both criteria are met and the retiree group health plan becomes a supplemental policy to Medicare. For full coverage, the Medicare-eligible retiree or dependent must **enroll in both Medicare Part A (Hospital) and Part B (Medical).** Those retirees/dependents who are eligible for Medicare and are not enrolled in Part B will be responsible for paying the portion of the claim that Part B would have paid (80% of Medicare allowed amount) until Part B coverage becomes effective. If prescription coverage is elected, all Medicare eligible retirees and/or Medicare eligible dependent(s) will be automatically enrolled in the States ESI Medicare Part D (EGWP) as part of the overall prescription drug benefit. Please see the benefits guide or visit the DBM website at www.dbm.maryland.gov for additional information.

Please complete the chart below for yourself and/or anyone on the enclosed Summary Statement of Benefit Elections who is eligible for Medicare. **The requested information can be found on the red, white and blue Medicare Card or by calling Medicare at 1(800) 999-1118. If possible, please attach a copy of the Medicare card.**

Name of Individual with Medicare*	**Medicare Number** *with suffix letter; Ex:123-45-6789-A*	**Part A - Hospital Effective Date** *Required for full medical coverage)*	**Part B - Medical Effective Date** *Required for full medical coverage)*	**Part D – Prescription Drug Effective Date** *Other than The State Prescription Drug Plan*	**Indicate Reason for Medicare Entitlement (√):**		
					Age 65+	Disabled	Kidney Failure (ESRD)
Retiree:							
Spouse/Domestic Partner:							
Child:							

If this form is enclosed with a letter, and the form is not returned within 30 days, your coverage level will be changed according to the information provided in the accompanying letter.

If you have any questions regarding this information, please call the Employee Benefits Division at (410) 767-4775 or toll-free outside the Baltimore Metropolitan area at 1 (800) 307-8283. Thank you very much.

_____ _____
Retiree's Signature Date