SUPERIOR COURT OF CALIFORNIA
COUNTY OF SANTA CLARA

Human Resources
191 North First Street
San José, California 95113
Telephone: (408) 882-2703
Fax: (408) 882-2796
Email: RetireeBenefits@scscourt.org

CERTIFICATION OF MEDICARE STATUS

This form is being completed for: ☐ Court Retiree ☐ Dependent of Retiree ☐ Survivor of Retiree

Sign and date the form and return it to:
Superior Court of California, County of Santa Clara 191 North First Street, San José, CA 95113.
Complete Section 1, 5 *(if applicable)*, 6 and either Section 2, 3, or 4.

SECTION 1: Please complete the following information

Name of Court Retiree: *(Last Name, First Name)*	Retiree's ID:
Name of Dependant/Survivor of Retiree	Dependant/Survivor of Retiree SSN

SECTION 2: For Retiree or Dependent/Survivor of Retiree enrolled in Medicare Part A and B

☐ I am enrolled in Medicare Part A and Medicare Part B. Ths is the information reflected in my red, white and blue Medicare card or Notice of Enrollment from the Social Security Aministration *(please attach copy)*

Medical Claim Number: _____

HOSPITAL (PART A) effective date: _____

HOSPITAL (PART B) effective date: _____

SECTION 3: For Retiree or Dependent/Survivor of Retiree claiming Medicare Ineligibility

☐ I am not eligible for Medicare Part A *(in my own right or through the work history of a current, former, or deceased spouse)*. I have verified this with the Social Security Administation and have attached documentation of this fact.

SECTION 4: For Retiree or Dependent/Survivor of Retiree who works and has Employer Group Health Plan Coverage

☐ I have deferred Medicare Part B enrollment due to working beyond age 65 and have coverage in my/my spouse's Employer Group Health Plan. I have attached documentation of this fact.

1. Name of Current Employer: _____

2.Name of Group Health Plan provided by employer: _____

SECTION 5: For Retiree ONLY – Requirement to enroll in Medicare Statement of Understanding

☐ I understand once I am enrolled in Medicare Part B, I must contact Human Resources and enroll in a Medicare plan. Should I no longer be enrolled in Medicare Part B or become ineligible for Medicare Part B, I will notify Human Resources immediately.

SECTION 6: Retiree or Dependent/Survivor of Retiree Signature

☐ I certify that the above information is true and correct and that I have read and understood these requirements.

_____ _____
Signature Date

Print Form