

Superior Court of California
County of Santa Clara

Human Resources
191 North First Street
San José, CA 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

Please complete **Section 1, 5 (if applicable), 6** and either Section **2, 3, or 4**. 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.

SECTION 1: Please complete the following information

| | |
|-------------------------------|--------------------------------|
| Name: (Last Name, First Name) | Retiree's ID or last 4 of 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. This is the information reflected on my red, white and blue Medicare card or Notice of Entitlement from the Social Security Administration (*please attach copy*):

| | |
|-----------------------------------|-------|
| Medical Claim Number: | _____ |
| HOSPITAL (PART A) effective date: | _____ |
| MEDICAL (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 Administration 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