

Keenan

HealthCare

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In compliance with federal legislation: **MEDICARE SECONDARY PAYER (MSP) MANDATORY INSURER REPORTING REQUIREMENTS OF SECTION 111 OF THE MEDICARE MEDICAID, AND SCHIP EXTENSION ACT OF 2007**, we are required to report all Plan Participants that are Medicare eligible.

Due to the new legislation your employer will be required to collect and report the Social Security and Health Insurance Claim Numbers (HICN) of all eligible policy holders and their covered dependents effective January 1, 2009.

All Medicare eligible policyholders and Medicare eligible dependents you intend to cover under your employer's group health insurance plan will be required to provide the event which qualifies them for Medicare coverage and the date coverage became effective.

Individuals are eligible for Medicare health insurance if one or more of the qualifying events apply:

- Age 65 or older,
- Under age 65 with certain disabilities,
- Any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Please return this form to: **Keenan, P.O. Box 2744, Torrance CA. 90509**

Please call **877-ENLOE99 (877-365-6399)** with any questions.

Non compliance with this request is subject to penalties and delays in processing your claims.

Please fill in the blank portions where appropriate. If you have more than one dependent, please enter information for each dependent. We appreciate your cooperation.

Member's Name	Medicare Coverage	Coverage Effective Date
_____	Yes _____ No _____	_____
Social Security Number	HICN Number	Coverage (check all that apply)
_____	_____	Part A: ___ Part B: ___ Part C: ___ Part D: ___
Reason: Over Age 65___	Totally Disabled___	End Stage Renal Disease___

1) Dependent name	Medicare Coverage	Coverage Effective Date
_____	Yes _____ No _____	_____
Social Security Number	HICN Number	Coverage (check all that apply)
_____	_____	Part A: ___ Part B: ___ Part C: ___ Part D: ___
Reason: Over Age 65___	Totally Disabled___	End Stage Renal Disease___

Signature

Date

(over)

Member Name:

2) Dependent name	Medicare Coverage	Coverage Effective Date
_____	Yes ___ No ___	_____
Social Security Number	HICN Number	Coverage (check all that apply)
_____	_____	Part A: ___ Part B: ___ Part C: ___ Part D: ___
Reason: Over Age 65___	Totally Disabled___	End Stage Renal Disease___

3) Dependent name	Medicare Coverage	Coverage Effective Date
_____	Yes ___ No ___	_____
Social Security Number	HICN Number	Coverage (check all that apply)
_____	_____	Part A: ___ Part B: ___ Part C: ___ Part D: ___
Reason: Over Age 65___	Totally Disabled___	End Stage Renal Disease___

4) Dependent name	Medicare Coverage	Coverage Effective Date
_____	Yes ___ No ___	_____
Social Security Number	HICN Number	Coverage (check all that apply)
_____	_____	Part A: ___ Part B: ___ Part C: ___ Part D: ___
Reason: Over Age 65___	Totally Disabled___	End Stage Renal Disease___

5) Dependent name	Medicare Coverage	Coverage Effective Date
_____	Yes ___ No ___	_____
Social Security Number	HICN Number	Coverage (check all that apply)
_____	_____	Part A: ___ Part B: ___ Part C: ___ Part D: ___
Reason: Over Age 65___	Totally Disabled___	End Stage Renal Disease___

Signature

Date

Please make copies of this page if needed for additional dependents.