EMPLOYEE FORM FOR NOT PROVIDING SOCIAL SECURITY NUMBER FOR DEPENDENT

I am an employee of a Seventh-day Adventist Organization of the North American Division of Seventh-day Adventists and am eligible to participate in the Healthcare Assistance Plan for Employees of Seventh-day Adventist Organizations of the North American Division Aka Ascend To Wholeness Healthcare Plans (the "Plan"), and I am now seeking to enroll one or more of my eligible dependents in the Plan.

I hereby certify that one or more of my dependents either does not currently have a United States Social Security number or I am refusing to provide the Social Security number for one or more of my dependents.

In order to enroll my dependent(s) in the Plan without providing a Social Security number, I agree to complete the attached form that is required by the Centers for Medicare & Medicaid Services, including my reason(s) for refusal to provide a Social Security number (for example, my dependent not having a Social Security number due to my employment in the United States on a visa/work permit).

I further agree that I will complete the required Centers for Medicare & Medicaid Services form accurately and completely, and that I will indemnify the Plan for any losses sustained by the Plan due to my inaccurately or incompletely filling out the Centers for Medicare & Medicaid Services form.

I acknowledge that I will have to complete the required Centers for Medicare & Medicaid Services form annually until I provide a Social Security number to the Plan for each of my enrolled dependent(s).

Signature:______________________________________

Print Name: ____________________________________

Employer Name: _________________________________

Date: ____

This form is not required until a newborn reaches age one or an adopted child has been placed for adoption for one year.

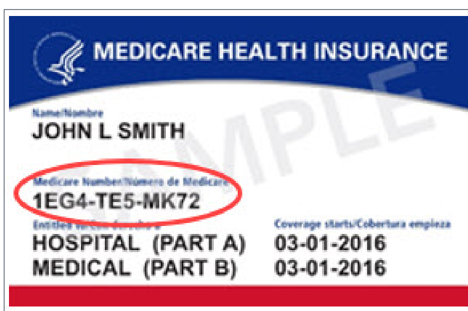
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that entities serving as group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plan administrators and fiduciaries report specific information about Medicare beneficiaries who have other group health coverage. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act amended this obligation to mandate the inclusion of primary prescription drug coverage in this reporting as of January 1, 2020. This reporting is to help CMS to properly coordinate payment of benefits among plans so that your medical claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you, a spouse, or other family members covered by your group health plan have, or has ever had, a similar Medicare card.

Please note the Medicare Number located on this card.



Section I

Are you presently, or have you ever been, enrolled in Medicare?			☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.				
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*				
Medicare Number:		**Date of Birth (Mo/Day/Year)**	/ /	
****Social Security Number:** *(If Medicare Number is Unavailable)*	- -	**Sex**	☐ Female	☐ Male

Section II

Do you have a spouse that is presently, or has ever been, enrolled in Medicare?	□ Yes	□ No
If yes, please complete the following. If no, proceed to Section III.		
Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	/ /
****Social Security Number:** *(If Medicare Number is Unavailable)* - -	**Sex** □ Female	□ Male

Section III

Do you have another covered family member that is presently, or has ever been enrolled in Medicare?	□ Yes	□ No
If yes, please complete the following. If no, proceed to Section IV. If additional space is needed for completion of this section, please attach another sheet.		
Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*		
Relationship *(Dependent child, domestic partner, etc.)*:		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	/ /
****Social Security Number:** *(If Medicare Number is Unavailable)* - -	**Sex** □ Female	□ Male

Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*		
Relationship *(Dependent child, domestic partner, etc.)*:		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	/ /
****Social Security Number:** *(If Medicare Number is Unavailable)* - -	**Sex** □ Female	□ Male

Full Name: *(Please print the name exactly as it appears on their SSN or Medicare card if available.)*		
Relationship *(Dependent child, domestic partner, etc.)*:		
Medicare Number:	**Date of Birth (Mo/Day/Year)**	/ /
****Social Security Number:** *(If Medicare Number is Unavailable)* - -	**Sex** □ Female	□ Male

** Note: If you, your spouse, and/ or your family member(s) are unable to provide the Medicare Number **and** uncomfortable providing the full Social Security Number (SSN), you may provide the last **5** digits of the SSN in the appropriate spaces.

Section IV

I understand that the information requested is to assist my insurer, third-party administrator, or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

______________________________ ______________________________

Subscriber Name (Please Print) **Subscriber's Plan ID**

____

Name of Person Completing This Form (Please Print)

____ ______________________________

Signature of Person Completing This Form **Date**

If you have completed Sections I – IV above, stop here. If you are refusing to provide the information requested in Sections I – IV, proceed to Section V.

Section V

______________________________ ______________________________

Subscriber Name (Please Print) **Subscriber's Plan ID**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

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____ ______________________________

Signature of Person Completing This Form **Date**