Certification of Medicare Status

Please complete Section 1, and either Section 2, 3 or 4. Sign and date the form and return it to CalPERS at P.O. Box 942715, Sacramento, CA 94229-2715.

Section 1: Please enter the Member's/Dependent's name and CalPERS ID.

<table>
<thead>
<tr>
<th>CalPERS Retiree Name:</th>
<th>CalPERS Retiree CalPERS ID:</th>
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<thead>
<tr>
<th>Medicare-Eligible Member/Dependent:</th>
<th>Member/Dependent CalPERS ID:</th>
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Section 2: For Member/Dependent 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:

Name of Medicare Beneficiary:

Medicare Claim Number: __________________________________________

HOSPITAL (PART A) effective date: __________________________________

MEDICAL (Part B) effective date: ___________________________________

Section 3: For Member/Dependent claiming Medicare Ineligibility

☐ I am not eligible for premium-free 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 Member/Dependent 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’s Group Health Plan and have attached documentation of this fact.

1. Name of your current employer
2. Name of your Group Health Plan provided by your employer

Section 5: Member/Dependent Signature

I certify that the above information is true and correct.

_________________________________________________________  _________________________________
Signature                                                                                       Date (mmddyyyy)

_________________________________________________________
Daytime telephone number

Revised 08/13