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

_____ Print Name

_____ Daytime Phone #

_____ Email

_____ Zip Code associated with Medicare Card

Reset Form