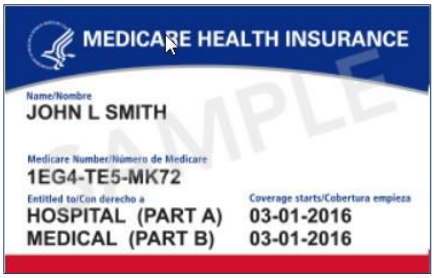
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program.

Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	□ 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

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide thelast 5 digits of your SSN in the section above.

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) | **Medicare Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

DocuSigned by:
8C9B0AC01EFC400...

2/12/2024

Signature of Person Completing This Form | **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) | **Medicare Number**

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:

DocuSigned by:
8C9B0AC01EFC400...

2/12/2024

Signature of Person Completing This Form | **Date**