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CMS-L564: Request for Employment Information

DEPARTMENT OF HEALTH AND HUMAN SERVICES Form Approved CENTERS FOR MEDICARE & MEDICAID SERVICES OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

WHAT IS THE PURPOSE OF THIS FORM?

In order to apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse's current employment. People with disabilities must have large group health plan coverage based on your, your spouse's or a family member's current employment.

This form is used for proof of group health care coverage based on current employment. This information is needed to process your Medicare enrollment application.

The employer that provides the group health plan coverage completes the information about your health care coverage and dates of employment.

HOW IS THE FORM COMPLETED?

Form CMS-L564 (CMS-R-297) (09/16)

- Complete the first section of the form so that the employer can find and complete the information about your coverage and the employment of the person through which you have that health coverage.
- The employer fills in the information in the second section and signs at the bottom.

WHAT DO I DO WITH THE FORM?

Fill out Section A and take the form to your employer. Ask your employer to fill out Section B. You need to get the completed form from your employer and include it with your Application for Enrollment in Medicare (CMS-40B). Then you send both together to your local Social Security office. Find your local office here: www.ssa.gov.

GET HELP WITH THIS FORM

- Phone: Call Social Security at 1-800-772-1213.
- En español: Llame a SSA gratis al 1-800-772-1213 y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- In person: Your local Social Security office. For an office near you check www.ssa.gov.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB No. 0938-0787 REQUEST FOR EMPLOYMENT INFORMATION SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance) 1. Employer's name 2. Date 3. Employer's Address City State Zip code 4. Applicant's Name 5. Applicant's Social Security Number 6. Employee's Name 7. Employee's Social Security Number **SECTION B:** To be completed by Employers For Employer Group Health Plans ONLY: ☐ Yes \square No 1. Is (or was) the applicant covered under an employer group health plan? 2. If yes, give the date the applicant's coverage began. (mm/yyyy) ☐ Yes \square No 3. Has the coverage ended? 4. If yes, give the date the coverage ended. (mm/yyyy) 5. When did the employee work for your company? Still Employed: (mm/yyyy) From: (mm/yyyy) To: (mm/yyyy) 6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer. From: (mm/yyyy) To: (mm/yyyy) For Hours Bank Arrangements ONLY: □No Yes 1. Is (or was) the applicant covered under an Hours Bank Arrangement? □No ☐ Yes 2. If yes, does the applicant have hours remaining in reserve? 3. Date reserve hours ended or will be used? (mm/yyyy) **All Employers:**

Download and print to PDF

Note: Download your information to PDF before printing.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850. Form CMS-L564 (CMS-R-297) (0 9/1 6)

Form Approved OMB No. 0938-0787

STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS APPLICATION

SECTION A:

The person applying for Medicare completes all of Section A.

1. Employer's name:

Signature of Company Official

Title of Company Official

Write the name of your employer. 2. **Date:** Write the date that you're filling out the Request for Employment

Information form. 3. Employer's address:

Write your employer's address. 4. Applicant's Name:

Write your name here.

5. Applicant's Social Security Number: Write your Social Security Number here.

6. Employee's Name: If you get group health plan coverage based on your employment,

write your name here. If you get group health plan coverage through another person, like a spouse or family member, write their name. 7. Employee's Social Security Number: If you get group health plan coverage based on your employment,

write your Social Security Number here. If you get group health

plan coverage through another person, like a spouse or family member, write their Social Security Number. **Once you complete Section A:** Once Section A is completed, give this form to your employer to

complete Section B. Once Section B has been completed by your employer, return this form along with your Part B application to your

local Social Security office. **SECTION B:** The employer completes all of Section B.

health plan? Please check yes or no if the applicant was covered under your

1. Is (or was) the applicant covered under an employer group

If you're an employer without an hours bank arrangement, complete

the section called "For Employer Group Health Plans ONLY"

be the employee or another person related to the employee, such as a spouse or family member with disabilities. If your company doesn't offer a group health plan, please check No. A group health plan is any plan of one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or their families. 2. If yes, give the date the coverage began. Write the month and year the date the applicant's coverage

group health plan offered by your company. The applicant may

began in your group health plan.

3. Has the coverage ended? Check yes or no if the group health plan coverage for the

applicant has ended.

4. If yes, give the date the coverage ended. Write the month and year the group health plan coverage 5. When did the employee work for your company?

Date Signed

Phone Number

Write the start and end dates of the employment for the employee in which the applicant is related. It may be the applicant or another person related to the employee, such as a spouse or family member with disabilities.

Enter the month and year of the start of the employment in the "From" box. Enter the month and year of end of the employment in the "To" box.

If the employee is still employed, enter the month and year of the current date. Current employment is active working status. It is not disability or

retirement. 6. If you're a large group health plan and the applicant is disabled,

please list the timeframe (all months) that your group health plan was primary payer. Write the start and end dates that your group health plan was

primary payer for the applicant.

section called "For Hours Bank Arrangements ONLY" 1. Is (or was) the applicant covered under an hours bank

If you're an employer with an hours bank arrangement, complete the

arrangement? Please check yes or no if the applicant was covered under an hours

bank arrangement. If you check no, please also fill out the section for "Employer Group Health Plans ONLY". 2. If yes, does the applicant have hours remaining inreserve?

Please indicate if the applicant currently has health coverage based on the remaining hours in the employee's hours bank account. 3. Date reserve hours ended or will be used?

Please write the month and year for when the remaining hours in the employee's hours bank account expired or will expire.

All employers need to complete the bottom of Section B.

• Signature of Company Official: An official representative of the company needs to sign this

document. Please do not print. Date Signed:

Write the date that you sign the form in this field.

Print the title of the company official who signed the form in this field. • Phone Number:

• Title of Company Official:

form in this field. If there are questions regarding the information on this form, a representative from Social Security will contact you.

Write the phone number of the company official who signed the

ended for the applicant..

INSTRUCTIONS: Form CMS-L564 (CMS-R-297) (09/16)

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Get email updates

About CMS

Email Sign up 🔼 you@example.com

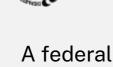
Helpful Links CMS & HHS Websites Tools USA Government Sites Medicare.gov Web Policies Freedom of Information About Us Acronyms Act Medicaid.gov Archive **Privacy Policy** Careers No Fear Act InsureKidsNow.gov Plain Language Newsroom Contacts Inspector General HealthCare.gov Glossary **Privacy Settings** Blog **USA.gov** Nondiscrimination & HHS.gov Podcast

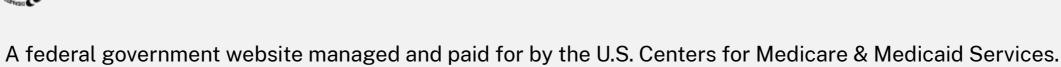
Accessibility

Developer Information

CMS.gov

HHS.gov/Open





7500 Security Boulevard, Baltimore, MD 21244



