

MEDICARE AND COBRA INFORMATION UPDATE

Group Name: _____

Group Number: _____

State of Issue: _____

Please consider the total number of employees, including full-time, part-time and those at additional locations, as you respond to the questions below.

Medicare Determination:

Have you employed 20 or more full-time and part-time employees each working day for 20 or more calendar weeks during the last 12 months?

Yes (Group Plan Primary) No (Medicare Primary)

Are you aware of any employees, spouses or children who are covered by Medicare due to disability? If yes, please provide their names.

COBRA Determination:

Have you employed 20 or more full-time and part-time employees on at least 50% of your working days during the last 12 months?

Yes (COBRA) No (Other continuation options
may be available)

I certify that the information above is true and correct to the best of my knowledge.

Signature: _____ **Title:** _____
(Owner, Partner or Corporate Officer)

Print Name: _____ **Date:** _____