



NORTH AMERICAN DIVISION
Healthcare Assistance Plan

Employee Form for Not Providing Social Security Number for Dependent

I am an employee of a Seventh-day Adventist Organization of the North American Division of Seventh-day Adventists and am eligible to participate in the Healthcare Assistance Plan for Employees of Seventh-day Adventist Organizations of the North American Division Aka Ascend To Wholeness Healthcare Plans (the "Plan"), and I am now seeking to enroll one or more of my eligible dependents in the Plan.

I hereby certify that one or more of my dependents either does not currently have a United States Social Security number or I am refusing to provide the Social Security number for one or more of my dependents.

In order to enroll my dependent(s) in the Plan without providing a Social Security number, I agree to complete the attached form that is required by the Centers for Medicare & Medicaid Services, including my reason(s) for refusal to provide a Social Security number (for example, my dependent not having a Social Security number due to my employment in the United States on a visa/work permit).

I further agree that I will complete the required Centers for Medicare & Medicaid Services form accurately and completely, and that I will indemnify the Plan for any losses sustained by the Plan due to my inaccurately or incompletely filling out the Centers for Medicare & Medicaid Services form.

I acknowledge that I will have to complete the required Centers for Medicare & Medicaid Services form annually until I provide a Social Security number to the Plan for each of my enrolled dependent(s).

Signature: _____

Print Name: _____

Employer Name: _____

Date: _____

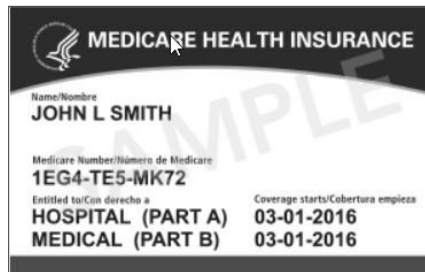
**This form is not required until a newborn reaches age one or an adopted child has been placed for adoption for one year.*

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you, a spouse, or other family members covered by your group health plan have, or has ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? <input type="checkbox"/>																						<input type="checkbox"/> Yes <input type="checkbox"/>			<input type="checkbox"/> No <input type="checkbox"/>										
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.)																																			
xx xx																																			
Medicare Number: <input type="checkbox"/>																						Date of Birth (Mo/Day/Year) <input type="checkbox"/>		<input type="checkbox"/>		/ <input type="checkbox"/>		<input type="checkbox"/>		/ <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
**Social Security Number: <input type="checkbox"/>																		- <input type="checkbox"/>			- <input type="checkbox"/>			Sex <input type="checkbox"/>		<input type="checkbox"/> Female <input type="checkbox"/>			<input type="checkbox"/> Male <input type="checkbox"/>						
(If Medicare Number is Unavailable)																																			

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

Section II

Do you have a spouse that is presently, or has ever been, enrolled in Medicare Part A or Part B?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please complete the following. If no, proceed to Section III.</i>			
Full-Name: <i>(Please print the name exactly as it appears on their SSN or Medicare card if available.)</i>			
Medicare-Number:		Date-of-Birth- (Mo/Day/Year)	
Social-Security-Number: <i>(If Medicare Number is Unavailable)</i>		Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male

Section III

Do you have another covered family member that is presently, or has ever been, enrolled in Medicare Part A or Part B?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please complete the following. If no, proceed to Section IV. If additional space is needed for completion of this section, please attach another sheet.</i>			
Full-Name: <i>(Please print the name exactly as it appears on their SSN or Medicare card if available.)</i>			
Relationship <i>(Dependent child, domestic partner, etc.)</i>			
Medicare-Number:		Date-of-Birth- (Mo/Day/Year)	
Social-Security-Number: <i>(If Medicare Number is Unavailable)</i>		Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male

Full-Name: <i>(Please print the name exactly as it appears on their SSN or Medicare card if available.)</i>			
Relationship <i>(Dependent child, domestic partner, etc.)</i>			
Medicare-Number:		Date-of-Birth- (Mo/Day/Year)	
Social-Security-Number: <i>(If Medicare Number is Unavailable)</i>		Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male

Full-Name: <i>(Please print the name exactly as it appears on their SSN or Medicare card if available.)</i>			
Relationship <i>(Dependent child, domestic partner, etc.)</i>			
Medicare-Number:		Date-of-Birth- (Mo/Day/Year)	
Social-Security-Number: <i>(If Medicare Number is Unavailable)</i>		Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male

Section IV

I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Subscriber Name (Please Print)

Subscriber's Plan ID

Name of Person Completing This Form (Please Print)

Signature of Person Completing This Form

Date

If you have completed Sections I – IV above, stop here. If you are refusing to provide the information requested in Sections I – IV, proceed to Section V.

Section V

Subscriber Name (Please Print)

Subscriber's Plan ID

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:

Signature of Person Completing This Form

Date