CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

Division of Rehabilitation and Liquidation
www.myfloridacfo.com/division/receiver

<DATE>

<NAME>
<ADDRESS>
<ADDRESS #2>
<CITY, STATE, ZIP>

RE: Receivership: Guarantee Insurance Company
Claimant:
Date of Loss:
Claim Number:
RCN: 550-

Dear: <NAME>

Under the Medicare Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173), which is implemented by the Center for Medicare and Medicaid Services (CMS), certain mandatory reporting requirements may apply to the claim you submitted to the Florida Department of Financial Services, Division of Rehabilitation and Liquidation (DEPARTMENT).[1] The DEPARTMENT is required to determine whether you are eligible for Medicare benefits, and if so, to report information regarding your claim to CMS.

In order for us to determine whether you are Medicare eligible, we request that you complete the enclosed Affidavit of Medicare Eligibility Form. The information you provide will be used only to determine your Medicare status and to enable us to meet our CMS reporting obligations. Additional information is available on the CMS website at: https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/overview.html

To expedite the review of your claim, please complete the information requested on the Affidavit of Medicare Eligibility Form and return the Affidavit to the Department by AUGUST 15, 2019.

Please use your exact formal name as it appears on your social security card (no nicknames).

Since SSN information is included, please submit the attached through our secured site: https://attach.fldfs.com

Sincerely,

[1] *See* Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), 42 U.S.C. § 1395y(b)(8).

Affidavit of Medicare Eligibility Form

(LEGAL NAME)

First Name _____ Middle Initial _____

Last Name _____

Gender: ☐ Male ☐ Female Date of Birth _____
MONTH / DATE / YEAR

Social Security Number (SSN) _____

Maiden name or other name(s) under which you have used the above SSN: _____

Please answer YES or NO to the following questions:

1. Have you reached the age of 64 and become entitled to receive either Social Security, Widow's/Widower's or Railroad Retirement benefits? YES____ NO____
2. If you are under age 64, have you received or applied for Social Security, Widow's/Widower's or Railroad Benefits? YES____ NO____
3. Have you treated for end-stage renal disease that has required dialysis treatment or kidney transplant? YES____ NO____
4. Are you 65 years or older, not eligible for either Social Security or Railroad Retirement benefits but have purchased Medicare coverage by monthly payment as an active employee for an employer with over 20 employees? YES____ NO____
5. Are you currently receiving Medicare benefits? YES____ NO____
6. Are you represented by an attorney? YES____ NO____
   If yes, provide: name, address, email, and telephone #: _____
7. Do you have a court appointed Guardian/Conservator? YES____ NO____
   If yes, provide: name, address, email, and telephone #: _____
8. Do you have someone who can legally act as your Power of Attorney? YES____ NO____
   If yes, provide: name, address, email, and telephone #: _____

If you answered YES to question(s) 1 – 5, please provide your Medicare Health Insurance Claim Number (HICN): _____

_____

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I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to certain action by Medicare including but not limited to possible penalties and fines and/or recovery of any funds improperly paid to me by Medicare in connection with the above-referenced claim.[2]

Signature _____ Date _____

[2] *See, e.g.*, 42 U.S.C. § 1395y(b)(2)(B)(iii) and 42 Code of Federal Regulations § 411.24.