

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). 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 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? If yes, provide: name, address, email, and telephone #:	YES	_ NO
7. Do you have a court appointed Guardian/Conservator? If yes, provide: name, address, email, and telephone #:	YES	_ NO
8. Do you have someone who can legally act as your Power of Attorney? If yes, provide: name, address, email, and telephone #:	YES	_ NO
If you answered YES to question(s) $1-5$, please provide your Medicare Health Insurance Claim Number	er (HICN):	:
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I certify that the foregoing statements made by me are true. I am aware that if an	-	
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.