

MEDICARE/PSRSSTL ENROLLMENT INSTRUCTIONS FOR NEW RETIREES 65+ WHO HAVE MEDICARE PART A ONLY

Per the PSRSSTL Group Insurance Enrollment Policy, “any member or dependent who is eligible for Medicare must have both Parts A and B to be enrolled in PSRSSTL’s medical coverage. Additionally, Medicare will impose lifetime penalties for not enrolling in Part B coverage when eligible (unless you were enrolled in employer group coverage).

Medicare Part B Enrollment

1. Section A is completed by you.
2. Section B is completed by your HR. If you are with SLPS, please contact Rebecca Anderson at 314-345-2282 or schedule an appointment with her via <https://calendly.com/rebeccaslps>
3. Contact the Social Security Administration (“SSA”) at (800) 772-1213 to enroll (up to three months prior to your effective date). Request the local SSA office address so you can forward the necessary enrollment forms (CMS-L564 and CMS-40B) to the Social Security Administration.
 - a) **CMS-L564 – Request for Employment Information** - Section B must be completed by your Employer’s Human Resources Department. The purpose of the form is to confirm that you waived Part B because you were enrolled in employer-sponsored group health coverage. Completion of this form will keep Medicare from imposing a lifetime Part B late enrollment penalty; and
 - b) **CMS-40B – Application for Enrollment in Medicare – Part B (Medical Insurance)**. ***Your Part B effective date should be the same date your medical insurance starts with PSRSSTL.***

PSRSSTL Medical Enrollment

4. Mail both forms to the local SSA office address. A new Medicare card will be mailed to you.
1. Once you have been enrolled in Medicare Parts A and B, contact the PSRSSTL Insurance Specialist at (314) 534-7444, Ext. 3011 to discuss the medical plan options. Be prepared to provide your current prescription medication list so that the Insurance Specialist can assist you in selecting the plan that best fits your needs.
2. Complete the PSRSSTL Benefit Enrollment-Change Form and submit to the PSRSSTL office:
 - a) Email: monica.brewer@psrstl.org (scan as a separate document)
 - b) Fax: 314-533-0531
 - c) Drop Box: Outside the building, next to the door at the following address:
 - d) Mail to: Public School Retirement System of the City of St. Louis
3641 Olive Street, Suite 300
St. Louis, MO 63108

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

2. Do you wish to sign up for Medicare Part B (Medical Insurance)? YES

3. Your Name (Last Name, First Name, Middle Name)

4. Mailing Address (Number and Street, P.O. Box, or Route)

5. City

State

Zip Code

6. Phone Number (including area code)

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7. Written Signature (DO NOT PRINT)

SIGN HERE

8. Date Signed

/ /

**IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT
MUST SUPPLY THE INFORMATION REQUESTED BELOW.**

9. Signature of Witness

10. Date Signed

/ /

11. Address of Witness

12. Remarks

Please enroll me for Part B coverage
effective _____.

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 collection is 0938-1230. The time required to complete this information 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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:

1. Is (or was) the applicant covered under an employer group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. If yes, give the date the applicant's coverage began. (mm/yyyy)		
□□ / □□□□		
3. Has the coverage ended? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. If yes, give the date the coverage ended. (mm/yyyy)		
□□ / □□□□		
5. When did the employee work for your company?		
From: (mm/yyyy)	To: (mm/yyyy)	Still Employed: (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:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. If yes, does the applicant have hours remaining in reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Date reserve hours ended or will be used? (mm/yyyy)	
□□ / □□□□	

All Employers:

Signature of Company Official		Date Signed
		□□ / □□ / □□□□
Title of Company Official		Phone Number
		(□□□□) □□□□ - □□□□

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.