Medicare Resource Guide for State of Delaware Retires

Important Definitions

Special Enrollment Period (SEP)

If you are **over** 65 when you or your spouse retires from the State of Delaware and already have Medicare Part A, you must enroll in Medicare Part B to enroll in the State of Delaware Group Health Plan at retirement. You will need to have your Human Resources Department complete the CMS L-564 Request for Employer Information form, and you will need to complete the CMS 40B Application for Enrollment in Medicare Part B (Medical Insurance) form. Both forms must be submitted to the Social Security Administration to process your or your dependent's enrollment. You can obtain more information on the SEP at More Info: Special Enrollment Period (SEP) (ssa.gov).

Example 1: I am 67 and retired from the State of Delaware. I qualify for a SEP through Social Security due to my age at retirement. I will have my Human Resources Department complete the CMS L-564 Request for Employment form, and I will complete the CMS 40B Application for Enrollment in Medicare Part B (Medical Insurance) form and provide them to the Social Security Administration no less than 3 months before my active employer group health coverage ends.

Example 2: I turned 65 in January and am retiring in February. I do not qualify for a SEP, and I do not need to complete the CMS L-564 Request for Employment Information form or the CMS 40B Application for Enrollment in Medicare Part B (Medical Insurance) form as I am still in my Initial Enrollment Period through Social Security. To apply for Medicare Part A and B I can apply in person, over the phone, or online at https://www.medicare.gov/basics/get-started-with-medicare/sign-up/ready-to-sign-up-for-part-a-part-b.

Example 3: I turned 65 in January and am retiring in June. I qualify for a SEP through Social Security because I am outside my Initial Enrollment Period. I will have my Human Resources Department complete the CMS L-564 Request for Employment form, and I will complete the CMS 40B Application for Enrollment in Medicare Part B (Medical Insurance) form and provide them to the Social Security Administration no less than 3 months before my active employer group health coverage ends.

Note: COBRA and retiree health plans aren't considered coverage based on current employment. If you have that type of coverage, you will not be eligible for a SEP when it ends. To avoid paying a higher premium, make sure you sign up for Medicare when you are first eligible either during your Special Enrollment Period or your Initial Enrollment Period.

Initial Enrollment Period (IEP)

If you are collecting Social Security benefits and accept the automatic enrollment in Medicare Parts A and B your Medicare Part A and B will be effective on the first day of your 65th birth month. If you are not collecting Social Security benefits and must enroll in Medicare Parts A and B and enroll anytime in the 3 months before turning 65, your coverage will start with the month you are first eligible, which is typically first day of your 65th birth month. However, if your birthday is the 1st of the month, your coverage will start on the 1st of the month before your 65th birth month. If you enroll during the last 4 months, your coverage will start the 1st of the month after you sign up.

Example 1: I am turning 65 in July and retiring July 1st. I apply for Medicare Part A and Part B in April through the Social Security Administration. My Medicare Part A and Part B will start on the 1st day of my birth month (July).

Example 2: I am turning 65 in July and retiring in September. If I accept automatic enrollment, my Medicare Parts A and B will start effective July 1. If I do not and I submit my application in August, my coverage will be effective September 1st. I do not need to complete the CMS L-564 Request for Employment Information form or the CMS 40B Application for Enrollment in Medicare Part B (Medical Insurance) form as I am still in my Initial Enrollment Period through Social Security. To apply for Medicare Part A and B I can apply in person, over the phone, or online at https://www.medicare.gov/basics/get-started-with-medicare/sign-up/ready-to-sign-up-for-part-a-part-b.

Note: If your group health plan coverage or the employment it is based on ends during your initial enrollment period for Medicare Part B, you do not qualify for a SEP. Your initial enrollment period starts three months before you reach age 65 and ends three months after you turn 65.

Social Security Disability

Social Security Disability (SSD) refers to a person receiving SSD benefits who is eligible for Medicare Parts A and B. You or your dependent(s) are required to comply with the State of Delaware Group Health Insurance Eligibility and Enrollment rules when applying for coverage through the Office of Pensions. Individuals who receive SSD and are covered under a group health plan from either their own or a family member's current active employment are eligible for a Special Enrollment Period when their coverage ends, or they transition to a retiree health plan.

Example 1: I started collecting Social Security Disability in January 2019, have Medicare Part A, and my health coverage has been enrolled through my active/current employer group. When I retire, I will have my Human Resources Department complete the CMS L-564 Request for Employment form, and I will complete the CMS 40B

Application for Enrollment in Medicare Part B (Medical Insurance) form and provide them to the Social Security Administration no less than 3 months before my active employer group health coverage ends.

Important Websites

There are several areas within Social Security and Medicare's websites that are helpful if you are looking for more information or further assistance.

Planning for Medicare - https://www.ssa.gov/medicare.

More Information on the SEP - https://www.ssa.gov/help/iClaim_medSEP.html.

Sign up for Part B only - https://www.ssa.gov/medicare/sign-up/part-b-only.

Medicare - https://www.medicare.gov/.

Social Security - https://www.ssa.gov/.

Medicare costs - https://www.medicare.gov/basics/costs.

How Medicare works with other insurance - https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance.

Example Forms

Example of CMS L-564 Request for Employment form:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name: State of Delaware
2. Date: / /
3. Employer's Address: Your employer's address.
City
State
Zip Code
4. Applicant's Name: The person enrolling in Medicare Part B
5. Applicant's Social Security Number: – –
6. Employee's Name: The employee's name. This can differ from the applicant.
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? ☒ Yes ☐ No
2. If yes, give the date the applicant's coverage began. (mm/yyyy) / This is the date your health coverage began with you current employer.
3. Has the coverage ended? ☐ Yes ☐ No
4. If yes, give the date the coverage ended. (mm/yyyy) / This is the date that your coverage will end through your active employer.
5. When did the employee work for your company?
From: (mm/yyyy) Start date of Employment / To: (mm/yyyy) Last month of employment. / 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? ☐ Yes ☐ No
2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☒ 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 ( ) –

Example of CMS-40B Application for Enrollment in Medicare Part B (Medical Insurance) form:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1230
Expires: 01/25

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number ☐☐☐☐–☐☐☐–☐☐☐☐ The number on your Medicare Part A card.

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

3. Mailing Address (Number and Street, PO Box, or Route)

4. City | State ☐☐ | Zip Code ☐☐☐☐☐

5. Phone Number (Including Area Code) (☐☐☐) ☐☐☐–☐☐☐☐

6. Do you wish to sign up for Medicare Part B (Medical Insurance)? [X] YES

7a. Do you currently have (or did you have) coverage through an employer or union group health plan? (If yes, complete 7c.) [X] YES [ ] NO

7b. Are you currently (or were you) an international volunteer for a non-profit organization and have or had health coverage provided to you? (If yes, complete 7c.) [ ] YES [X] NO

7c. Enter dates of employment (or volunteer work) and health coverage below. (Enter all dates as MM/YYYY)

Dates you (or your spouse) worked for employer that provided health coverage:	Dates of health coverage from employer (or non-profit organization):	Dates you worked as a volunteer outside the U.S.:
Your dates of employment. Start Date: ☐☐/☐☐☐☐ Ending Date: ☐☐/☐☐☐☐ Not ended ☐	Your health coverage dates. The end date is your retirement date. Start Date: ☐☐/☐☐☐☐ Ending Date: ☐☐/☐☐☐☐ Not ended ☐	Start Date: ☐☐/☐☐☐☐ Ending Date: ☐☐/☐☐☐☐ Not ended ☐

8. Has an employer, health insurance provider, or other entity requested or required you to enroll in Part B? (If yes, explain how and why in the Remarks section, and include proof or documentation with this form.) [X] YES [ ] NO

9. Remarks: I or my spouse is retiring from the State of Delaware effective (enter your retirement effective date). Please make my Medicare Part B effective (enter your retirement effective date.

10. Written Signature (DO NOT PRINT) SIGN HERE | 11. Date Signed ☐☐/☐☐/☐☐☐☐

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

12. Signature of Witness | 13. Date Signed ☐☐/☐☐/☐☐☐☐

14. Address of Witness (Street Number and Name, City, State, Zip)