

**SAMPLE MEMO FOR MEDICARE PART B
(USE AGENCY OR NON-STATE EMPLOYER LETTERHEAD STATIONERY)**

MEMORANDUM

TO: Social Security Administration

FROM: (Agency or Non-State Employer)

DATE:

SUBJECT: STATEMENT OF EMPLOYER PROVIDED HEALTH PLAN COVERAGE

The following information is provided to enable the named Kansas State Employee Health Plan member to apply for Medicare Parts B and D coverage during the Special Enrollment Period.

Member's Name	Member's Social Security Number
Date of Coverage under the State Employee Health Plan	
Employee Retirement Date	
Date that the State Employee Health Plan will end as Primary Carrier	
Is the member's spouse covered under the State Employee Health Plan?	<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse's Name	Spouse's Social Security Number

OFFICIAL AGENCY OR PERSONNEL OFFICE SIGNATURE AND TITLE

Printed Name and Title	Phone Number including Area Code
Signature	Date