

**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.

<b>Member's Name</b>	<b>Member's Social Security Number</b>
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
<b>Spouse's Name</b>	<b>Spouse's Social Security Number</b>

**OFFICIAL AGENCY OR PERSONNEL OFFICE SIGNATURE AND TITLE**

<b>Printed Name and Title</b>	<b>Phone Number including Area Code</b>
<b>Signature</b>	<b>Date</b>