THIS FORM ONLY APPLIES TO YOU IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR MEDICARE AND ARE COVERED UNDER THE ROCKINGHAM COUNTY HEALTH PLAN

You should have received, or will be receiving, information about enrolling in a Medicare prescription drug plan. Rockingham County has determined that the prescription drug coverage offered by the County's Health Plan is considered Creditable Coverage and is expected to pay out as much as the standard Medicare prescription drug coverage plan. If you are on the County's Health Plan for prescription drug coverage but are eligible for Medicare, the County can seek reimbursement from the Centers for Medicare and Medicaid Services (CMS) for drug costs that could have been paid for by Medicare if you and/or your dependents had enrolled in a Medicare prescription drug plan. Basically, CMS is willing to reimburse the County for costs incurred when eligible employees, retirees, and/or their dependents buy prescriptions under the County's Health Plan since these same costs would have been covered if the employees, retirees, and/or their dependents had chosen to enroll in a Medicare prescription drug plan.

In order for the County to seek reimbursement from CMS, the County must submit a list of employees, retirees, and their dependents **who are covered by the County's Health Plan AND are eligible for Medicare**. Therefore, the County needs the following information if you and/or your dependents are eligible for Medicare. Please note that providing your and/or your dependents' social security number(s) is voluntary and will be used only for the above-stated purpose.

Are you, your spouse, or any dependents covered by Medicare? ☐ YES (if yes, please complete below section)

List all Medicare-eligible family members (including yourself, if eligible).

Full Name	*Date of Birth*	*Sex*	*Medicare # (as shown on card/SSN)*	*Relationship to Employee*	*Actively Employed Yes or No*	*Part "A" effective date*	*Part "B" effective date*	*Part "D" effective date*

BY MY SIGNATURE BELOW, I CERTIFY THE ABOVE INFORMATION IS CORRECT:

Name of Employee/Retiree (please print)_____ Date_____

*Signature of Employee/Retiree*_____

Submit this form as soon as possible to: Rockingham County Personnel, P.O. Box 210, Wentworth, NC 27375