MSP Participant Form
Health Reimbursement Arrangement (HRA)

beneliance

Employer Name _____ ☐ Male ☐ Female

(Please Print)
Last Name _____ First Name _____ Middle Initial _____

mm/dd/yyyy
Social Security Number _____ Date of Birth _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____

E mail Address (if any)_____

Medicare Secondary Payor (MSP) Reporting Information

Are you a Medicare beneficiary? ☐ Yes ☐ No If Yes, provide your Medicare HICN here _____

** **IMPORTANT:** If **your spouse or any of your dependents** are covered by the company group health insurance plan, please complete the form below (which continues onto the next page) for **each person** besides yourself who is covered by the plan.

Dependent #1

Name (Please Print) _____ ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____/_____/_____
mm/dd/yyyy

Relationship to you _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No If Yes, provide his/her Medicare HICN here _____

Dependent #2

Name (Please Print) _____ ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____/_____/_____
mm/dd/yyyy

Relationship to you _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No If Yes, provide his/her Medicare HICN here _____

Dependent #3

Name (Please Print) _____ ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____/_____/_____
mm/dd/yyyy

Relationship to you _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No If Yes, provide his/her Medicare HICN here _____

Dependent #4

Name (Please Print) _____ ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____/_____/_____
mm/dd/yyyy

Relationship to you _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No If Yes, provide his/her Medicare HICN here _____

please proceed to page 2

continued from page 1

Dependent #5

Name (Please Print) _____ ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____ /_____ /_____
mm/dd/yyyy

Relationship to you _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No If Yes, provide his/her Medicare HICN here _____

If you have more than five dependents covered by the health insurance plan, please provide the above information about each person on a separate sheet of paper and attach to this form.

I hereby certify information provided herein to be true and correct as of this date.

Employee Signature: _____ **Date:** _____ /_____ /_____
mm/dd/yy