INDIVIDUAL INSURANCE SOLUTIONS, LLC

**Part B Application - Request for Employment Information (Form L564)**

**SECTION A: Applicant/Employee that is signing up for Medicare B completes this section.**

1. Employer's Name (Company Name)
2. Date the application is completed
3. Pertains to employer that has provided group health insurance coverage. Employer's address (Company Address), City, State & Zip Code
4. Applicant's Name (**person applying for Medicare Part B: employee or spouse**)
5. Applicant's Social Security Number
6. Employee's Name – **Can be the same as Applicant if employee is applying for Medicare Part B)**
7. Employee's Social Security Number

**SECTION B: Employer/Plan Administrator completes this section:**

1. Is/was applicant covered under an employers group health plan (Yes/No)
2. Date coverage begin (month/year) – Generally start date of employment
3. Has coverage ended (Yes/No) – If coverage has already ended answer yes. If it ends in the future answer No.
4. If #3 is Yes, provide date it ended (month/year)
5. How long has the applicant worked for the company (From: month/year – To: month/year if still employed (month/year)
6. **Only needs to be completed if applicant is disabled**
   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: month/year To: month/year

**For Hours Bank Arrangements (DO NOT FILL OUT)**

**All Employers: Bottom of Page – COMPLETED BY COMPANY OFFICIAL**

**Sign, date, title of official signing application & phone number**

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