



**Section IV:**

I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

\_\_\_\_\_  
**Subscriber Name (Please Print)**

\_\_\_\_\_  
**Subscriber's Plan ID**

\_\_\_\_\_  
**Name of Person Completing This Form (Please Print)**

\_\_\_\_\_  
**Signature of Person Completing This Form**

\_\_\_\_\_  
**Date**

*If you have completed Sections I – IV above, stop here. If you are refusing to provide the information requested in Sections I – IV, proceed to Section V.*

**Section V:**

\_\_\_\_\_  
**Subscriber Name (Please Print)**

\_\_\_\_\_  
**Subscriber's Plan ID**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

**Reason(s) for Refusal to Provide Requested Information:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Person Completing This Form (Please Print)

\_\_\_\_\_  
Signature of Person Completing This Form/Date

After completing this form you should make a copy for your records and mail the original form to:

State Health Benefit Plan  
P.O. Box 1990  
Atlanta, GA 30301-1990

