Companion Instructions to Form "SSN – Refusal to Provide SSN"

Who should use this Form?

- Employees that have elected to participate in the group health plan offered through their employer.
- Spouses of the employee, that are covered under the employee's election to participate in the group health plan.
- Dependent children and domestic partners that are covered under the employee's election to participate in the group health plan.

When this Form should be completed: Employees and their covered family members should routinely cooperate in furnishing either their Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) as requested by the employee's group health plan.

- When the employee or the employee's covered family members that are covered under the employee's election to participate in the group health plan refuse to furnish his or her SSN, this Form should be completed.

What to do:

1. Go to www.cfablue.com/ Members/Forms / SSN - Refusal to Provide.
2. Determine if you, a spouse or other family members covered by the employee's election to participate in the group health plan has ever had a Medicare card. To see a sample Medicare card, refer to page 1 of the Form SSN-Refusal to Provide.

When the answer to #2 above is NO:

- If you, your spouse or covered family members have never been enrolled in Medicare Part A or Part B; OR
- if you, your spouse or covered family members have never had a Medicare card; AND
- you, your spouse or covered family members refuse to provide their SSN, then
- Go to page 2, Section V.
  a. Print the Subscriber Name - You, the employee enrolled in the group health plan through your employer, is considered to be the Subscriber for purposes of this Form.
  b. Fill in the Subscriber's Plan ID – This information is located on your CFA Membership ID Card under GROUP No.
  c. Reason for Refusal to Provide Requested Information - Write your reason for failing to provide your employer with your, your spouse's, or a covered family member's SSN.
  d. Print the Name of the Person Completing this Form – Under most circumstances, this will be your name, the name of the employee enrolled in the group health plan, but it may be someone else such as your spouse. If your spouse or some other person is completing this Form on your behalf, that person's name must be printed here.
  e. Sign and Date the Form – The Form must be signed and dated by the Person that completed the Form.
  f. Return pages 1 and 2 of the completed Form to your Human Resources Department / Benefits Department.

When the answer to #2 above is YES:

- If you, your spouse or covered family members
- have ever been enrolled in Medicare Part A or part B; OR
- if you, your spouse or covered family members have ever had a Medicare card; AND
- you, your spouse or covered family members refuse to provide their SSN, then
- Go to page 1 and answer the questions in Section I, Section II, Section III, and Section IV.

  Section I: Complete Section I if YOU, the employee enrolled in your employer's group health plan, have ever been enrolled in Medicare Part A or Part B.
  Section II: Complete Section II if YOUR SPOUSE, who is a covered participant in your employer's group health plan, has ever been enrolled in Medicare Part A or Part B.
  Section III: Complete Section III if any of YOUR other family members are enrolled in your employer's group health plan, and have ever been enrolled in Medicare Part A or Part B
  Section IV:
  a. Print the Subscriber Name - You, the employee enrolled in the group health plan through your employer, is considered to be the Subscriber for purposes of this Form.
  b. Fill in the Subscriber's Plan ID – This information is located on your CFA Membership ID Card under GROUP No.
  c. Print the Name of the Person Completing this Form – Under most circumstances, this will be your name, the name of the employee enrolled in the group health plan, but it may be someone else such as your spouse. If your spouse or some other person is completing this Form on your behalf, that person's name must be printed here.
  d. Sign and Date the Form – The Form must be signed and dated by the Person that completed the Form.
  e. Return pages 1 and 2 of the completed Form to your Human Resources Department / Benefits Department.