Step 1:
Confirm this information is entered correctly.

Small Employer Exception Submittal Certification

Employer Name: ____ABC Company, Inc._____

Employer Address: ___5555 Main Street, Cleveland, OH 44444_____

We certify that we have not had 20 or more employees on each working day in 20 or more calendar weeks in the current or preceding calendar year.

We employ _____ employees.

Step 2:
Enter the highest number of employees, both full and part time, employed on any one payroll during the preceding 20 weeks.

Employer Identification Number (EIN): ___99-9999999__ _____

Employer Tax Identification Number (TIN): _____

_____
Employer Representative Name

Step 3:
A representative of your company must sign. A copy of the signed form is acceptable, it is not required that you maintain the original signed form. Note: The representative can not be the same person listed as the Medicare Beneficiary.

_____
Signature of Employer Representative Date

Step 4:
The Plan Manager (Consoliplex) signs as Submitter Representative

____Annette Cutright __
Submitter's Representative Name

_____
Signature of Submitter's Representative Date

Page 2 - Confirmation:
Confirm this information is entered correctly.

Small Employer Exception (SEE) Request:

Request for Exception for Working Aged Individuals and Spouses Aged 65 and Over

Date: _____ Submitter: Builders Exchange Benefit Plan

TIN/EIN: 99-9999999

Employer Name: ABC Company, Inc.

The above referenced employer participates in a multiple employer plan as defined by 42 CFR 411.101.

Employees who have coverage under the group employee health benefit plan are eligible for coverage either by virtue of their current employment status with the above referenced employer or as a spouse of a covered employee.

The above listed employer hereby requests the exception of the Medicare Secondary Payer status for the following working aged employee(s) and/or spouse(s) aged 65 or over who is/are employed by the employer listed above.

Page 3 - Final Step:
Verify the information entered is correct. You must enter the Employee or Dependent Health Insurance Claim Number ("HICN") or Social Security Number ("SSN") for this Small Employer Exemption request to be successful.

SEE Package-1.0, June 2015:

Medicare Beneficiary	Employee Name	HICN/ SSN	DOB	Coverage Type: A, J, K	Coverage Effective Date	Action Code: A, C, D	Effective Date of Change	Reason Code: A, B, C, D
John Smith	John Smith	123-45-6789	01/01/1950	A	1/1/2017 *Effective date with BEX plan	A	*This box will be left blank for new requests.	*This box will be left blank for new requests.

*The Plan Manager (Consoliplex) will sign as Submitter Representative.

Submitter's Representative Name:_Annette Cutright___

Submitter's Representative Signature: _____

Date: _____

Additional Information:

The following two pages contain additional instructions provided by CMS detailing how to complete the prior page.

COB&R Coordination of Benefits and Recovery

Instructions for Completing the Small Employer Exception (SEE) Request

This document may be used to request a SEE, or to request a change or update to a previously approved SEE.

Note: For new requests, a certification must be submitted along with the SEE Document.

A change request should only be submitted when the original conditions of a previously approved SEE no longer apply or because a previously approved SEE was submitted in error and must be withdrawn.

If the request is being made by an authorized insurer, the insurer must provide evidence, such as a signed authorization, that it is authorized to act on behalf of the multi or multiple employer plan.

Field:	**Description:**
Date	Current Date
Name of Submitter	Name of Company Submitting Request
TIN/EIN	Employer Tax Identification Number (TIN) or Employer Identification Number (EIN) *Required for change request
Name of Medicare Beneficiary	Medicare Beneficiary Name
Name of Employee	*Required if Medicare Beneficiary's Name differs from Employee's Name
HICN/SSN	Medicare Beneficiary's Health Insurance Claim Number (HICN) or Social Security Number (SSN) if HICN is not available.
DOB	Medicare Beneficiary's Date of Birth (DOB)
Coverage Type	Coverage Type: • A = Medical and Hospital • J = Hospital Only • K = Medical Only *Required for new SEE request

Field:	Description:
Coverage Effective Date	Date the employer sponsored health insurance coverage began. *Required for new SEE request
Submitter's Representative Signature	Signature of Submitter's Representative
Name of Submitter's Representative	Printed Name of Submitter's Representative
Action Code	A – Add C – Change D – Delete
Employer Name	Employer Name *Required for change request
Effective Date of Change	The date the specified change takes place. *Required for change request
Change Request Reason Code	Reason for change request: • A – Employee no longer works for employer on SEE • B – Spouse no longer works for employer on SEE • C – Employer no longer qualifies for SEE (More than 20 employees.) • D – Withdrawal of SEE (Submitted in error.) *Required for change request