Your Future — Our Focus

Chicago Regional Council of Carpenters
Welfare, Pension and Supplemental Retirement Funds

12 East Erie Street • Chicago, Illinois 60611
(312) 787-9455 • Kristina M. Guastaferri, Administrator
www.crccbenefits.org

Re: Collection of Health Insurance Claim Numbers ("HICN") or
Social Security Number ("SSN") for Mandatory Medicare Reporting

Dear Participant:

Effective January 1, 2009, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires the Chicago Regional Council of Carpenters Welfare Fund ("the Fund") to collect specific information about participants and all of their covered dependents who are or may become eligible for Medicare due to age, disability, kidney disease, or having received a kidney transplant. The Fund must then report the information to the Centers for Medicare and Medicaid Services (CMS) or face a significant financial penalty.

As a result of a new federal law, the Fund is now required to gather and confirm additional information about (1) you or your dependent with End Stage Renal Disease (ESRD) **or** (2) for your totally disabled dependent, who is covered under the Welfare Fund.

We may already have some of the necessary information; however, to ensure complete accuracy of our data and to comply with federal law, we are requesting that you complete the back side of this letter for the individual(s) on Medicare Parts A or B.

We understand that this request may be an imposition. However, CMS, the federal agency that oversees Medicare, is requiring Funds like ours to collect and submit this data - or face fines of $1,000 per day per person for whom we do not submit the information.

Exception to the Reporting Rules: The government has now provided an exception to the reporting rule, and thus an opportunity for the Fund to avoid penalty. To use the exception, the Fund Office must obtain a signed copy of the form on the reverse side of this notice from any participant who refuses to provide his/her SSN or HICN.

Please complete the form on the reverse side of this notice and return it as soon as possible to the Fund Office, Attn: Membership Desk, along with a copy of the applicable Medicare card for (1) the individual with End Stage Renal Disease (ESRD) or (2) for your totally disabled dependent. If you prefer, you may fax the completed form, along with the applicable Medicare card, to (312)-951-1515.

Thank you for your cooperation. To speak to one of our Participant Service Representatives, please call 312-787-9455, Menu Option 3, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Sincerely,

The Board of Trustees

(Complete the form and return it to the Fund Office.)

CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND
12 E. Erie St. • Chicago, IL 60111
312-787-9455, Phone Option 3
Fax: 312-951-1515

* H I C N *

COLLECTION OF SOCIAL SECURITY NUMBERS OR HEALTH INSURANCE CLAIM NUMBERS (HICN) FOR MANDATORY MEDICARE REPORTING

To ensure complete accuracy of our data and to comply with federal law, we are requesting the following information for the individual on Medicare Parts A or B. If more than one individual in your household is on Medicare, please copy form.

1. Name: _____
   (Clearly print name **exactly** as listed on the Medicare Card for the Individual with ESRD or is Totally Disabled)

2. Medicare Claim/Card: _____
   (For Individual listed in Item #1 above)

3. Social Security Numbers: _____
   (For Individual listed in Item #1 above) **(SS# is mandatory if you do not provide HICN)**

4. Date of birth: _____ 5. Gender: ☐ Male ☐ Female (check one)
   (For Individual listed in Item #1 above)

6. Relationship to Participant: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

I understand that the information requested is to assist the Chicago Regional Council of Carpenters Welfare Fund to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare Law.

_____ _____
Participant's Name (please print clearly) Participant's ID. Number (as listed on BCBS ID Card)

_____ _____
Signature of Participant Today's Date

****

Exception to the Reporting Rules: If you do not choose to provide the SSN and/or HICN for yourself or any of your dependents, you must still sign and submit the form to the Welfare Fund Office.

For the reasons 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.

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

_____

_____

_____

_____ _____
Participant's Name (please print clearly) Participant's ID. Number (as listed on BCBS ID Card)

_____ _____
Signature of Participant Today's Date