EMPLOYEE BENEFITS
County of Riverside Human Resources
Great Benefits For A Great Place To Work

Supplement to Enrollment Form

Spouse / Dependent Information

Please complete each of the sections below. If you do not have a spouse or qualified dependents, check the box in the appropriate section. Claims you submit on behalf of your spouse or any qualified dependents will not be paid until the enrollment information requested below is on file with your plan's third-party administrator. We collect this information as required by and in accordance with federal law.

Mail or fax completed form to: REHN & ASSOCIATES, P.O. Box 5433, Spokane, WA 99205-0433 or (509) 535-7883.

If you're already a participant, **submit your information online** and skip the paper form. Simply login to your account and click on the link to enter and submit the information. Login instructions can be found on your participant activity statement.

You are being asked to complete this form in accordance with a new Medicare secondary payer (MSP) reporting law. The law was enacted by Congress as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Effective January 1, 2009, the law requires your plan's third-party administrator to have on file the full name, Social Security number, gender, and date of birth for all participants, spouses, and dependents to be covered under the plan. Data is reported quarterly to the Centers for Medicare & Medicaid Services (CMS) through a secure reporting system.

1. PARTICIPANT INFORMATION

Participant Name: _____ _____ _____ Gender: ❑ Male ❑ Female
First Last MI

DOB: _____ Social Security Number: _____

Phone: _____ E-mail: _____

2. SPOUSE INFORMATION

❑ **I do not have a spouse.** If your marital status changes, you may add a spouse later using an Account Information / Fund Allocation Change Form.

Spouse Name: _____ _____ _____ Gender: ❑ Male ❑ Female
First Last MI

DOB: _____ Social Security Number: _____

3. DEPENDENT INFORMATION

❑ **I do not have any dependents.** If your family status changes, you may add dependent(s) later using an Account Information/Fund Allocation Change Form.

If you have more than three dependents, please write the required information on the reverse or on a separate piece of paper and attach it to this form.

Dependent Name: _____ _____ _____ Gender: ❑ Male ❑ Female
First Last MI

DOB: _____ Social Security Number: _____

Dependent Name: _____ _____ _____ Gender: ❑ Male ❑ Female
First Last MI

DOB: _____ Social Security Number: _____

Dependent Name: _____ _____ _____ Gender: ❑ Male ❑ Female
First Last MI

DOB: _____ Social Security Number: _____

4. SIGNATURE

_____ _____
Signature of Participant Date