

**BLUE CROSS AND BLUE SHIELD OF ILLINOIS (BCBSIL)
 MEDICARE SECONDARY PAYER (MSP)
 EMPLOYER ACKNOWLEDGEMENT FORM (EAF)**



BlueCross BlueShield of Illinois
 Experience. Wellness. Everywhere.™

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the enclosed document titled "Instructions – Completing the MSP Employer Acknowledgement Form" for more details. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Please complete this form, sign, date, and return to BCBSIL as soon as possible.**

Employer Name – Legal Name of Company:		Employer Identification Number (EIN):
Physical Address (number & street), City, State, ZIP:		
Account Number(s):	Group Number(s):	
⇒ New BCBSIL clients please check the correct box	<input type="checkbox"/> The client was not in business during the preceding calendar year	<input type="checkbox"/> The client was in business during the preceding calendar year
⇒ Current BCBSIL clients please check the correct box	<input type="checkbox"/> Submitting this EAF at renewal	<input type="checkbox"/> Submitting this EAF as an update <input type="checkbox"/> Submitting this EAF as an error correction
Do you have any affiliates or subsidiaries? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", list name of each:		

IMPORTANT NOTE: Some of the following responses are based on the current calendar year, while others are based on the preceding year. Unless making an update or error correction, please use the year of your upcoming renewal as 'current year' when answering the following questions. For example, if your upcoming renewal is effective July 1, 2009, base your current year answers on 2009. Or, if your upcoming renewal is effective January 1, 2010, base your current year answers on 2010. Please indicate the current calendar year for which the form is being completed: _____. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSIL if and when your status changes.

1. In the year immediately prior to the current calendar year, did you file a separate federal tax return, that is, not consolidated with another individual or entity? If you are not required to file a federal tax return, please check N/A <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. How many employees did all the entities on the preceding calendar year's tax return have on the payroll (whether full-time, part-time, seasonal, or partners) during the preceding calendar year? Enter number of employees.	_____ (# of employees)	
3. During the current year are you part of a multi-employer group health plan? The term "multi-employer group health plan" means any trust, plan, association or any other arrangement made by one or more employers or by employers and unions to offer, contribute to, sponsor, or directly provide health benefits.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇒ Check 'Yes' or 'No' for both the current and preceding calendar years <input type="checkbox"/> If you checked "Yes" for the current calendar year, and the threshold was met during the current year, please check this box and enter the date the threshold was met in the following space. ____/____/_____ <input type="checkbox"/> If you check "No" for the current year and your answer changes to "Yes" at any time, you must promptly notify BCBSIL by completing a new EAF, checking this box and entering the date the threshold was met in the space above.	Current year (See Important Note above.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Preceding year	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If you are currently or were during the preceding year part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇒ If you answered 'Yes' to #3, then check 'Yes' or 'No' for both the current and preceding calendar years ⇒ If you answered 'No' to #3, then check 'Yes' or 'No' for the preceding calendar year only	Current year (See Important Note above.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Preceding year	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I understand that BCBSIL is relying on my answers to the above questions to determine whether Medicare will be the primary payer of claims for my Medicare eligible insured(s). I certify that the answers are true to the best of my knowledge and belief. I also understand that I am responsible to promptly notify BCBSIL, as indicated above, if my answers to the above questions change because we have increased the number of employees.

 Signature of company officer or authorized representative

 Print Name

 Title

 Date