Instructions for Small Employer Exception (SEE) Submittal Certification

The certification document is required for any new SEE request. This certification should be completed by the employer and contain signatures both from the employer and the submitter.

Note: The signatures cannot be dated more than one calendar year prior to the date of the exception request. This document must accompany each new SEE request, and all information is required. This document is not needed when requesting an update or delete of an existing, previously approved SEE.

Table 1: SEE Submittal Certification Fields

Field	Description
Employer Name	Printed name of the employer certifying less than 20 employees
Employer Address	Printed address of the employer certifying less than 20 employees
Number of Employees Statement	Number of employees employed by the certifying employer
Employer Identification Number (EIN)	EIN *Required if no TIN
Tax Identification Number (TIN)	TIN of employer *Required if no EIN
Employer Representative Name	Printed name of the employer's representative
Signature of Employer Representative	Signature of the employer's representative
Date	Date of the employer's representative signature
Submitter's Representative Name	Printed name of the submitter's representative
Signature of Submitter's Representative	Signature of the submitter's representative
Date	Date of the submitter's representative signature

Small Employer Exception Submittal Certification

Employer Name: _____

Employer Address: _____

Address Line 2: _____

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.

Employer Identification Number (EIN): _____

Employer Tax Identification Number (TIN): _____

_____
Employer Representative Name

_____
Signature of Employer Representative Date

_____
Submitter's Representative Name

_____
Signature of Submitter's Representative Date

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of a previously approved SEE no longer apply or because a previously approved SEE was submitted in error and must be withdrawn.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.

Table 2: SEE Request Fields

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
Medicare ID/SSN	Beneficiary's Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) or Social Security Number (SSN) if Medicare ID is not available.
DOB	Medicare beneficiary's date of birth
Coverage Type	Coverage Type: A = Medical and Hospital J = Hospital Only K = Medical Only *Required for new SEE requests
Coverage Effective Date	Date the employer sponsored health insurance coverage began *Required for new SEE request
Submitter's Representative Signature	Signature of the submitter's representative
Name of Submitter's Representative	Printed name of the submitter's representative

Field	Description
Action Code	Action Code: A – Add C – Change D – Delete
Employer Name	Employer name *Required for change requests
Effective Date of Change	The date the specified change takes place *Required for change requests
Change Request Reason Code	Reason for the 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 requests

Small Employer Exception (SEE) Request

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

Date: _____ Submitter: _____

TIN/EIN: _____

Employer Name: _____

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.

Table 3: Request for Exception for Working Aged Individuals and Spouses Aged 65 and Over Details

Medicare Beneficiary	Employee Name	Medicare ID/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

Submitter's Representative Name: _____

Submitter's Representative Signature: _____

Date: _____