

To Be Filed with CMS ON-line at www.cms.hhs.gov/apps/ccdisclosure/default.asp



CMS Centers for Medicare & Medicaid Services

File Before 9/1/06 or 12/1/2006 for certain school/groups
Creditable Coverage Disclosure to CMS Website

Please refer to the Disclosure to CMS Guidance at <http://www.cms.hhs.gov/CreditableCoverage/> for detailed information when completing this form.

Complete the following information for each Type of Coverage offered by the Entity/Plan Sponsor:

Name of Entity Offering Coverage

Entity Federal ID Number ex: XX-XXXXXXXX

Street Address of Entity

City State Zip Code

Phone Number of Entity ex: xxx-xxx-xxxx

Type of Coverage (Choose One):

GROUP HEALTH PLAN:

- Employer Sponsored Plan
- Union/Taft Hartley Sponsored Plan
- Church
- Federal Government
- State Government
- Local Government
- Other Entity

STATE-SPONSORED PLANS:

- Medicaid
- State Pharmacy Assistance Program (SPAP)
- State High Risk Pool
- Other State-Sponsored

Plan:

MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205):

- Standardized Plan (H, I, J)
- Pre-standardized Plan
- Waiver State Plan
- Innovative Benefit Rider

INDIVIDUAL HEALTH INSURANCE (Non-Medigap Plans)
 VETERANS COVERAGE (under Chapter 17 of Title 38 U.S.C.)
 MILITARY COVERAGE (under Chapter 55 of Title 10, U.S.C., including TRICARE)
 INDIAN HEALTH SERVICE
 TRIBE OR TRIBAL ORGANIZATION
 URBAN INDIAN ORGANIZATION
 OTHER TYPE OF COVERAGE OFFERED TO MEDICARE PART D ELIGIBLE INDIVIDUALS
 Please Fill in Type of Plan:

* **BASED ON # of Active PLANS offered**

How many Prescription Drug Options offered under this Coverage? *

KA+, KA 200, KA300, KA500, HDHP and Kaiser each count AS ONE.

Please Select **One** of the following and an additional box will appear for you to complete the required disclosure information.

- All Options Offered Are Creditable.**
- All Options Offered Are Non-Creditable.
- There are some Creditable or Non-Creditable Options Offered.

You have select All Options Offered Are Creditable.

Period covered by this Disclosure:

- Plan Year Beginning Date (MM/DD/YYYY) Plan Year Ending Date (MM/DD/YYYY) **SCHOOL GROUPS MAY BE 10/01/2006 - 09/30/2007**
- Total Number of Medicare Part D Eligible Individuals expected to be covered under these Option(s) as of the Plan Year Beginning Date stated above:
- Estimated number of those Medicare Part D Eligible individuals stated above expected to be covered through an Employer/Union **Retiree** Group Health Plan
- Date that the Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the entity (MM/DD/YYYY) **Date you sent our letter of**
- Is this a change to a previous disclosure of creditable coverage status provided to CMS? Yes No
 - If yes, include the effective date(s) of this change (MM/DD/YYYY)
 - If yes, date Entity completed the disclosure to Medicare Part D Eligible Individuals of this change in Creditable Coverage (MM/DD/YYYY)

I understand and agree to the following statements:

- That this submission supersedes any previous submission of this information with dates prior to the date below;
- That the entity/plan sponsor agrees to disclose to CMS and all Medicare Part D eligible individuals any changes that would affect the creditable status of the above coverage as

outlined under §423.56.

- That I am authorized to supply this disclosure of credible coverage on behalf of the Entity; and
- That the information provided in this disclosure is true, correct, and complete to the best of my knowledge and belief.

(Name of Entity's Authorized Individual)

(Title)

(Email of Entity's Authorized Individual)

Date (MM/DD/YYYY)