Actively Employed Information Form
(Formerly the TEFRA/DEFRA Election Form)

Complete this form if the employer that you will continue to have health care coverage from has 20 or more employees. If your employer has less than 20 employees, **STOP!** Medicare is your primary payer. **Do NOT complete this form.**

Complete this section if **you** are an MVP Health Care plan member who is age 65 or older and will remain actively employed.

Your Name:	MVP Health Care Plan Member Number:
Address:	
City, State, ZIP:	
Your Employer:	Your Medicare ID Number

I certify that I will continue to work at my current place of employment and will continue its active employee health coverage. I will notify MVP Health Care three months before I leave employment with this employer.

Signature: ____ Date: ___________________

Complete this section if **your spouse** is actively employed with health care that covers you.

Your Name:	Your Member Number:
Spouse's Name:	Spouse's Date of Birth:
Address:	
City, State, ZIP:	
Spouse's Employer:	Spouse's Medicare Number:

I certify that I will continue to be covered by the active employee health care coverage of my spouse. I will notify MVP Health Care three months before my spouse leaves employment.

Signature: ____ Date: ___________________

Inquiries: Call MVP's Medicare **Customer Care Center**
1-800-209-3945 or TTY: **1-800-662-1220**
Monday – Friday, 8 am – 8 pm, Saturday, 8 am – 4 pm Eastern Time
From Nov. 15 – Mar. 1, call seven days a week, 8 am – 8 pm