

# Retiree Drug Subsidy (RDS) Authorized Representative Verification

*Type or Print*

## 1. Reason for Submission:

- Initial Submission  Correcting a Rejected Form  
 Reassigned Authorized Representative  Other (explain): \_\_\_\_\_

2. Authorized Representative's Name

3. Authorized Representative's Title

4. Plan Sponsor Name

5. Plan Sponsor ID (NOT EIN)

6. Verifier's Name (NOT the Authorized Representative)

7. Verifier's Job Title

8. Verifier's E-Mail Address

9. Verifier's Telephone Number (include area code)

10. Verifier's Company Address

*Street Address*

*City*

*State*

*Zip Code*

11. Verifier's Signature

12. Date

This document is a confirmation for purposes of the Centers for Medicare & Medicaid Services' (CMS) Retiree Drug Subsidy (RDS) Program, that the individual named in (2) above is acting as the Authorized Representative. Note that an Authorized Representative MUST be an individual employed by the Plan Sponsor to whom the Plan Sponsor has granted the legal authority to bind the Sponsor to the terms of the Plan Sponsor Agreement in the RDS application. Examples of the Authorized Representative include the Sponsor's general partner, CFO, CEO, president, Human Resources Director, or an individual who holds a position of similar status and authority within the Sponsor's organization. For multi-employer plans, the Authorized Representative does not have to be an employee of the Sponsor, but may be a member of the jointly appointed board of trustees, which includes both labor and management trustees.

Return the completed Authorized Representative Verification form to:

**E-mail:** [RDSPayment@cms.hhs.gov](mailto:RDSPayment@cms.hhs.gov)

**Fax:** 646-458-2280

**Mailing address:** Retiree Drug Subsidy Center, Attn: Authorized Representative Verification Unit, P.O. Box 5032, New York, N.Y. 10274-5032