

Retiree Drug Subsidy (RDS) Authorized Representative Verification

Type or Print

Note: The Verifier who completes and signs this form must be an employee of the Plan Sponsor. For multi-employer plans, the Verifier may be an employee, or a member of the jointly appointed board of trustees, which includes both labor and management.

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 Email Address

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

10. Verifier's Company Address

By signing this form, I, the Verifier, am representing to the Federal government **that I have actual knowledge** that the Plan Sponsor has granted this individual the legal authority to bind the Sponsor to the terms of the Plan Sponsor Agreement in the RDS Application.

11. Verifier's Signature

12. Date

Send the completed Authorized Representative Verification form to **one** of the following locations:

Email Address: rds_forms@cms.hhs.gov **Fax:** 646-458-2280

Mailing Address: Retiree Drug Subsidy Unit
Attn: AR Verification Unit
P.O. Box 5032
New York, NY 10274-5032