



**STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
2026 SILVERSCRIPT PART D PRESCRIPTION DRUG PLAN HIGH-
INCOME SURCHARGE VERIFICATION**



LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	
<i>If you are covered as the spouse of an OGB plan member, enter their information below.</i>			
OGB PLAN MEMBER'S LAST NAME	OGB PLAN MEMBER'S FIRST NAME	OGB PLAN MEMBER'S SSN	
<i>Each person covered by OGB's SilverScript Medicare Part D plan has a separate ID card that contains the member number for that person.</i>			
SILVERSCRIPT MEDICARE MEMBER #		OGB PLAN MEMBER'S SILVERSCRIPT MEDICARE ID #	
STREET ADDRESS	CITY	STATE	ZIP CODE

Your Monthly High-Income Part D Premium Surcharge Amount (Select One):

- Deducted from your monthly Social Security check
- Invoiced to you by Centers for Medicare & Medicaid Services (CMS) every quarter or month

SIGNATURE

DATE

PRIMARY TELEPHONE NUMBER	ALTERNATE PHONE NUMBER
EMAIL ADDRESS	

Return this completed form and a copy of the Medicare letter that informed you of your Social Security benefit for the plan year to:

Office of Group Benefits
Attention: Customer Service
P.O. Box 44036
Baton Rouge, LA 70804-4036
Fax: 225-342-9919
email: ogb.customerservice@la.gov