1199SEIU National Benefit Fund

330 West 42nd Street, New York, NY 10036-6977 • www.1199SEIUBenefits.org
Tel (646) 473-9200 • Outside NYC Area Codes: (800) 575-7771

Statement of Claim for Medicare Part B Premium Reimbursement

Filing Claims for Medicare Reimbursement

1. Claims may be filed on a quarterly, semi-annual or annual basis. To ensure proper reimbursement, please submit form SSA-1099 for each person for each claim year.
2. Eligible retirees* may submit a claim for 50% of the basic Medicare Part B premium for the retiree and spouse.
3. If this is your first time filing a claim for Medicare Part B premium reimbursement, you **must** include a copy of your Medicare Part B ID card with this form.
4. We will accept Medicare Part B premium claims for the current year and the two prior years.

*Eligibility is based on years of service and age at retirement. Check your Summary Plan Description for details.

Please print clearly in black or blue ink

1. Member's full name: ______________________________

   Date of birth: ______/______/____________ (Month / Day / Year) Telephone: (______) ______________________

2. Spouse's full name: ______________________________

   Date of birth: ______/______/____________ (Month / Day / Year) Telephone: (______) ______________________

3. Address: ______________________________

   City: ______________________ State: _____ Zip code: ____________

   Is this a new address? ☐ Yes ☐ No

4. Date of retirement: _______/______/__________ (Month / Day / Year)

5. Check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally separated

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6. Your Member ID: ______________________________

   ☐ Member's claim

Check box for months paid	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Year 20____

   ☐ Spouse's claim

Check box for months paid	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Year 20____

   Medicare Part B reimbursement will not be made for future time periods. Reimbursement will only be made up to and including the month the claim is received.

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7. Member's signature **X** ______________________________ Date: ______________

   I attest that the person(s) for whom reimbursement is being submitted has active Medicare Part B coverage and may be required to submit proof that the coverage is still in effect. Form will be returned if not signed.

Please complete and return to:
1199SEIU National Benefit Fund
PO Box 2661
New York, NY 10108-2661

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