



1199SEIU Benefit Funds

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 ESRD Medicare Part B Active Members National Benefit Fund - Greater New York Benefit Fund

Filing Claims For Medicare Part B Premium for Active, Working Members with End Stage Renal Disease (ESRD)

1. Claims can be filed as needed on a Quarterly, Semi-Annual or Annual basis.
2. Eligible active members or spouses* may submit a claim for 50% of the basic Medicare Part B Premium.
3. If this is your first time filing a claim for ESRD Medicare Part B Reimbursement, you must include a copy of your (of your spouse's) Medicare Part B ID card or premium statement from Medicare.

*Eligibility is based on active members or their spouses who have Medicare as their primary insurer due to ESRD.

Please Print Clearly in Black or Blue Ink

1. Member's Full Name: _____

Date of Birth: ____/____/____
 Month Date Year

Telephone: (____) _____

2. Spouse's Full Name: _____

Date of Birth: ____/____/____
 Month Date Year

Telephone: (____) _____

3. Address: _____

City: _____ State: _____ Zip Code: _____

Is this a new address? Yes No

4. Check One: Single Married Widowed Divorced Legally Separated

5. Your Member ID: _____

Member Claim

Check Box
for Mos. Paid

Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
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Year 20 ____

Spouse's Claim

Check Box
for Mos. Paid

Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
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Year 20 ____

6. **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 force. Form will be returned if not signed.

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