1199SEIU Benefit Funds

PO Box 2661, New York, NY 10108-2661 • Tel: (646) 473-9200 • Outside NYC: (800) 575-7771 • www.1199SEIUBenefits.org • ⓕ◎@1199SEIUBenefitfunds

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)

Please print clearly in black or blue ink or complete online.

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 (or 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.

MEMBER'S FULL NAME (FIRST, LAST) _____ DATE OF BIRTH (MM/DD/YYYY) _____

SPOUSE'S FULL NAME (FIRST, LAST) _____ DATE OF BIRTH (MM/DD/YYYY) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Is this a new address? ☐ Yes ☐ No

Check One: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Your Member ID#: _____

☐ Member Claim

Check Box(es) for Months Paid	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Year 20 _____

☐ Spouse's Claim

Check Box(es) for Months Paid	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Year 20 _____

X _____

MEMBER'S SIGNATURE DATE (MM/DD/YYYY)

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