1199SEIU National Benefit Fund

PO Box 2661 • New York, NY 10108-2661 • (646) 473-8666 • Outside NYC: (800) 575-7771 • www.1199SEIUBenefits.org

STATEMENT OF CLAIM FOR MEDICARE PART B PREMIUM REIMBURSEMENT

Please print clearly in blue or black ink.

Filing claims for Medicare Part B premium reimbursement:

- Claims may be filed once every quarter, but no later than two years after the premium payment. To ensure proper reimbursement, please submit Form SSA-1099 for each person for each claim year.
- Eligible retirees may submit a claim for 50 percent of the standard Medicare Part B premium for the retiree and spouse. ***Eligibility is based on years of service and age at retirement. Check your Summary Plan Description for details.***
- If this is your first time filing a claim for Medicare Part B premium reimbursement, you must include copies of your Medicare Part B ID card and Form SSA-1099 with this form.
- The Fund will accept Medicare Part B premium reimbursement claims only for premiums paid in the last two years.

▲REQUIRED FIELD

▲MEMBER ID#

▲MEMBER'S LAST NAME | MEMBER'S FIRST NAME

▲MEMBER'S DATE OF BIRTH (MM/DD/YYYY) | ▲MEMBER'S PRIMARY PHONE

▲MEMBER'S ADDRESS | ▲CITY | ▲STATE | ▲ZIP CODE

▶Is this a new address? ☐ Yes ☐ No

▲SPOUSE'S LAST NAME | SPOUSE'S FIRST NAME

▲SPOUSE'S DATE OF BIRTH (MM/DD/YYYY) | ▲SPOUSE'S PRIMARY PHONE

▲SPOUSE'S ADDRESS | ▲CITY | ▲STATE | ▲ZIP CODE

▶Is this a new address? ☐ Yes ☐ No

SUBMIT ONE CLAIM PER YEAR

MEMBER'S CLAIM				SPOUSE'S CLAIM			
▶CLAIM YEAR 20____________				▶CLAIM YEAR 20____________			
▼Check boxes for months claimed:				▼Check boxes for months claimed:			
☐ January	☐ April	☐ July	☐ October	☐ January	☐ April	☐ July	☐ October
☐ February	☐ May	☐ August	☐ November	☐ February	☐ May	☐ August	☐ November
☐ March	☐ June	☐ September	☐ December	☐ March	☐ June	☐ September	☐ December

NOTE: 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.

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. This form will be returned to me if not signed and dated.

X ____

▲MEMBER'S SIGNATURE | ▲DATE