

# 1199SEIU National Benefit Fund

PO Box 2661, New York, NY 10108-2661 • Tel: (646) 473-8666 • Outside NYC: (800) 575-7771 • Fax: (646) 473-7089 • www.1199SEIUBenefits.org

## STATEMENT OF CLAIM FOR MEDICARE PART B PREMIUM REIMBURSEMENT

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

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 a copy of your Social Security Benefit Verification Letter 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 Health Insurance card and one of the following: a payment voucher, a Social Security Benefit Verification Letter or proof of Medicare Part B premium payment.
- 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			
► CLAIM YEAR <u>20</u>			
▼ Check boxes for months claimed:			
<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November
<input type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> December

SPOUSE'S CLAIM			
► CLAIM YEAR <u>20</u>			
▼ Check boxes for months claimed:			
<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November
<input type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> 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 (MM/DD/YYYY)

Return completed form by mail to 1199SEIU Benefit Funds, PO Box 2661, New York, NY 10108-2661; by fax to (646) 473-7089; or by email to RetireeHealth@1199Funds.org.

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