1199SEIU National Benefit Fund

@1199SEIUBenefitFunds

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 Administration Award 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 Administration Award 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.

All fields required.

MEMBER ID#

MEMBER'S FIRST NAME | MEMBER'S LAST 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 FIRST NAME | SPOUSE'S LAST 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 20______ Check boxes for months claimed:				**SPOUSE'S CLAIM** CLAIM YEAR 20 ______ 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 (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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