



# 1199SEIU National Benefit Fund

PO Box 2661, New York, NY 10108-2661 • (646) 473-9200 • www.1199SEIUBenefits.org

## Statement of Claim for Medicare Part B Premium Reimbursement

FILING CLAIMS FOR MEDICARE REIMBURSEMENT

1. Claims can be filed as needed on a Quarterly, Semi-Annual or Yearly basis
2. Eligible retirees\* may submit a claim for 50% of the basic Medicare Part B Premium for the Retiree and Spouse.
3. If this is your first time filing a claim for Medicare Part B Premium Reimbursement, you must include a copy of your Medicare Part B ID card with this form.

**Please Print Clearly in Black or Blue Ink**

1. Your Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Tel. No. \_\_\_\_\_
2. Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Tel. No. \_\_\_\_\_
3. Address \_\_\_\_\_  
\_\_\_\_\_

Is this a new address?  Yes  No

4. Retired \_\_\_\_\_  
Date of Retirement \_\_\_\_\_

5. Check One: Single  Married  Widowed  Divorced  Legally Separated

6. Your Health Benefit ID # \_\_\_\_\_

Member Claim

Check Mos. Paid 

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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 Year 20 \_\_\_\_\_

Spouse's Claim

Check Mos. Paid 

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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 Year 20 \_\_\_\_\_

Total Reimbursement of Premium Claimed: Yourself \$ \_\_\_\_\_ Spouse \$ \_\_\_\_\_

7. Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT PRINT**

**Remarks**

\*Eligibility is based on years of service and age at retirement. Check your Summary Plan Description for details.