

APPLICATION / RECERTIFICATION  
 FOR MEDICARE REIMBURSEMENT

CITY RETIREE INFORMATION (Always Complete)

Social Security Number

NAME AND MAILING ADDRESS (Please PRINT Clearly)

NAME AND ADDRESS CORRECTION:

Last Name		First Name		M.I.
Home Address - Number and Street				
City		State	Zip Code	Telephone Number: ( )
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Date of Event / /
City Agency From Which Retired		Retirement Date / /		Name of Union or Welfare Fund
Retirement System	Years in Pension System.	Are you receiving a pension check? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Pension No. Name of Current Health Insurance Plan <input type="checkbox"/> None

SPOUSE INFORMATION (Complete only if currently married) (Do not complete if you are divorced or widowed)

Spouse Social Security Number		Last Name (if different)		First Name	M.I.
Date of Birth / /	Employed by or retired from New York City agency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is spouse to be covered by member? <input type="checkbox"/> Yes <input type="checkbox"/> No (Spouse may not be covered as both a member and a dependent)		Employment Status <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Employed	
Name & Address of Spouse's Current or Former Employer (including NYC)		Does spouse have coverage other than Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Health Insurance Carriers(s) and Policy Numbers	

DEPENDENT CHILDREN INFORMATION (List each eligible child covered by retiree's health insurance)

First Name	Last Name	Birth Date	Sex M/F	Check if permanently Disabled	This part for disabled child covered by Medicare			
					Medicare Number		Effective Dates	
					Claim Number	Suffix	Hosp. Ins. (Part A)	Med. Ins. (Part B)
							/ /	/ /
							/ /	/ /
							/ /	/ /

MEDICARE INFORMATION (Complete if retiree and / or spouse is covered by Medicare)

ATTACH MEDICARE CARD PHOTOCOPIES

	Medicare Number		Effective Dates	
	Claim Number	Suffix	Hospital Insurance (Part A)	Medical Insurance (Part B)
Retiree			/ /	/ /
Spouse			/ /	/ /

PLEASE READ THE FOLLOWING NOTES, THEN SIGN BELOW

- Form will be returned if incomplete. All eligible persons must sign below and attach Medicare card photocopies.
- If an eligible person has died, please mark "deceased" in the appropriate signature panel below and give the date of death.
- Your signature below affirms that you have not knowingly made a false statement; that you authorize the Social Security Administration to furnish information relative to your Medicare enrollment; that you understand that information supplied may be used by the City to appropriately adjust your health insurance status.

Signature of City Retiree	Signature Date / /	Date of Death (if Applicable) / /
Signature(s) of Spouse and/or Dependent	Signature Date / /	/ /