Benefit Fund for Hospital and Health Care Employees — Philadelphia and Vicinity
1319 Locust Street • Philadelphia, PA 19107-5405
215.735.5720 • 800.531.1199 • Fax 215.985.9232

Statement of Claim for Medicare Reimbursement

Please PRINT all information.

Your Name _____ Birth date _____ Phone number _____

Spouse's Name _____ Birth date _____ Phone number _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____ - _____

Date of retirement _____

Where working at retirement _____
Name of Institution *City* *State*

Social Security Number _____ ❑ Male ❑ Female

Wages for _____ *Fill in the year for which you are reporting wages* $ _____

Check one box only: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Legally Separated

If this claim is for reimbursement of Medicare premiums, fill in this section

Your Social Security Number _____

Place a check mark in the box for each month you have paid.

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Spouse's Social Security Number _____

Place a check mark in the box for each month you have paid.

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Member's signature _____ Date _____

You must attach a copy (keep the original for your records) of the Form 1099 you receive from the Social Security Administration for each year you are claiming reimbursement. If you are claiming reimbursement for more than one year, you must fill out one of these forms for each year. Return all paperwork to:

Benefit Fund for Hospital and
Health Care Employees --
Philadelphia and Vicinity
1319 Locust Street
Philadelphia, PA 19107-5405