



MEBA MEDICAL & BENEFITS PLAN
 MEBA PENSION TRUST
 MEBA TRAINING PLAN
 MEBA VACATION PLAN

Date Mailed : _____

BENEFIT PLANS

1007 EASTERN AVENUE, BALTIMORE, MARYLAND 21202-4345 • (410) 547-9111

**APPLICATION FOR MEDICARE PART "B" REIMBURSEMENT
 AND CONFIRMATION OF MEDICARE PART "B" COVERAGE**

Please complete all of the following information and read the statements below. Sign and date this Form, attach proof of Part "B" enrollment* and return all documents to the MEBA Plan Office at 1007 Eastern Avenue, Baltimore, MD 21202-4345.

Please Print Clearly

Member's Name: _____
 Street Address: _____

 Social Security #: _____
 Daytime Phone #: _____

This benefit is requested for (*list name and relationship to Member, including Member himself*):

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

In accordance with the Rules and Regulations of the MEBA Medical and Benefits Plan, I hereby certify the following:

1. *Each of the persons listed above is currently covered by Medicare Part "B" insurance. I am attaching proof of enrollment in Medicare Part "B" for each person listed above.*
2. *I will immediately notify the MEBA Plan Office if any person listed above should ever stop being covered by Medicare Part "B".*

Date: _____ Signature of Member: _____

* Acceptable proof of Medicare Part "B" enrollment is a copy of your (1) Medicare Card, or (2) Form SSA-1099 (Social Security Benefit Statement).
 These are the only acceptable forms of proof.