MEBA Medical & Benefits Plan
1007 Eastern Avenue
Baltimore, MD 21202-4345

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

****IN ORDER TO BE ELIGIBLE FOR REIMBURSEMENT, YOUR GROSS MONTHLY PENSION BENEFIT, CALCULATED AS A STRAIGHT LIFE ANNUITY, MUST BE LESS THAN $ 1,000.00 ****

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 above address.

Please Print Clearly

Member's Name: _____

Street Address: _____

_____

Social Security#: XXX-XX-_____

Daytime Phone#: _____

This benefit is requested for (list name and relationship to Member, <u>including</u> Member):

<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 **<u>each</u>** 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 ***<u>only</u>*** acceptable forms of proof.