

# Medicare Part B Annual Premium Reimbursement\* Request

## United Nations



Insurance and Disbursement Service, FF-300, 304 East 45<sup>th</sup> St. New York, NY 10017 – Tel: (212) 963-5813 – EMAIL: [ashi@un.org](mailto:ashi@un.org)

*\*Please note that the normal reimbursement method will be by decreasing the amount of your ASHI contribution. This form should be used to provide evidence of your Medicare premiums payments. If your payment amount is greater than your ASHI contribution, please also complete section 3 below.*

### SECTION 1 – ASHI participant *(Print all information clearly)*

Full Name(LAST, First)	Index Number	Retiree Number
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Mailing Address	Personal Email Address
	Telephone Number:

### SECTION 2 - Part B Premiums Claimed (maximum of 2 years)

*Please note that this reimbursement claim will not be valid without proof of payment (such as Form CMS-500 – “Notice of Medicare Premium Due”) attached.*

Name (Last, First)	Relationship to participant	Medicare ID	Coverage period		Monthly Premium Paid
			From:	To:	

### SECTION 3 - Bank information for EFT payment

*Please note that payment will only be effected in the event your Medicare premium is greater than your ASHI contribution.*

Bank Name:	
Account no:	Routing or ABA #, IBAN or SWIFT Code:

I declare that I will continue to make payments to Medicare for my Medicare Part B coverage and I understand that my claims will be adjudicated as if I had Medicare Part B regardless of my actual Medicare status.

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Signature

\_\_\_\_\_

Date