United Nations
Health & Life Insurance Section

# Medicare Part B Annual Premium Reimbursement Request

Please submit the completed form to: Health and Life Insurance Section (HLIS), Email: ashi@un.org – Fax: (917) 367-1670

***Please Note: Reimbursement will be made directly to the ASHI participant's bank account information on file.***

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

| Name *(Last, First)*: | Index Number: | Retiree Number: |
|---|---|---|
| | | |

| Mailing Address: | Personal Email Address: |
|---|---|
| | Telephone Number: |

## SECTION 2 - Part B Premiums Claimed

*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 No.: | Coverage period From: | To: | Monthly Premium Paid: |
|---|---|---|---|---|---|
| | | | | | |
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## SECTION 3 - Bank information for EFT payment

*Please fill out Section 3 if you are submitting for a reimbursement claim for the first time. If the reimbursement is for spouse only, please note that banking details should be the primary subscriber's account for a joint account, otherwise the claim will be rejected.*

| Bank Name: | |
|---|---|
| Account No.: | Routing or ABA #, IBAN or SWIFT Code: |

***I declare that I will continue to make payments to the SSA 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.***

_____ Signature

_____ Date *(DD/MM/YY)*