Medicare Part B Annual Premium Reimbursement Request

United Nations
Health & Life Insurance Section

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:

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 type (check only one): ○ Savings ○ Checking
Account No.:	Routing or ABA #, IBAN or SWIFT Code:

If your banking details have changed, please include a voided check for reimbursement into checking accounts.

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)*