

New York City District Council of Carpenters Health & Welfare Fund
PO Box 3799 Church Street Station
New York, NY 10008

Medicare Part B Premium Reimbursement Application

1. Name _____

Social Security Number _____

Age _____ Date of Birth _____

2. **Complete this section if you are claiming a reimbursement of premiums for your spouse who is receiving Medicare benefits.**

Spouse's Name _____

Spouse's Age _____ Spouse's Date of Birth _____

3. **Complete this section if you are in receipt of a Social Security Disability Award and are not yet receiving Medicare benefits. Please enclose a copy Of your award letter.**

Date of Entitlement _____

Premiums will only be paid to those enrolled in the Medicare Part B program and for months during which the participant is eligible and under 65 years of age.

Date: _____

Member' Signature _____

Spouse's Signature _____

Please enclose a copy of your Medicare Card and a copy of your next Social Security Check or bank statement indicating the current deposit. You need to send a copy of your Medicare card one time only.