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

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

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#: _____

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.

REV 2009-04