Telephone: (212) 541-9880

*EMPLOYER TRUSTEES*
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Health and Benefit Trust Fund
International Union of Operating Engineers
Local Union No. 94-94A-94B, AFL-CIO
331-337 West 44th Street
New York, NY 10036

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RAYMOND J. MACCO

# School Retiree
# Medicare Related Premium Reimbursement Form

Participant's Name: _____Participant's SS#: _____

Spouse's Name: _____ Spouse's SS#: _____

Address: _____

No. and Street Apartment #

_____

City State Zip Code

In order to be reimbursed for Medicare Related premiums from the Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No. 94-94A-94B, AFL-CIO ("Fund") that you (or your spouse) have paid during a calendar year, you (and your spouse) must send proof of such premium payments within one year following the end of the calendar year to the Fund Office. The following forms of proof are acceptable.

1. If you (or your spouse) have Social Security Income and/or Supplemental Security Income (collectively referred to as ("SSI")), and are qualified for Medicare, the following proof must be submitted:
   a. Form SSA-1099 Social Security Benefit Statement (this statement can be obtained from your local Social Security Office)
2. If you (or your spouse) do not qualify for SSI, but qualify for Medicare and pay premiums directly, the following proof must be submitted:
   a. "Proof of Income" Letter or "Proof of Award" Letter from Social Security. You can also request the form online via http://ssa.gov/onlineservices/. (It may take up to 30 days for delivery); **and**

   either:
   a. A cancelled check (front and back) and a copy of the quarterly invoice statement (CMS 500) from Social Security Office for the current year; **or**
   b. Latest bank or credit card statement showing the current premiums for Medicare Supplemental, Medicare Advantage and Medicare Plan D premiums charged against your account (please wipe out your account number).

Are you or your eligible spouse receiving reimbursement for the Medicare Premiums thru another carrier?
Yes □ No □

If you checked yes above, please list below the person who is receiving the reimbursement thru another carrier and provide the Explanation of Benefits (EOB) statement to the Fund Office when submitting your claim for the reimbursement of the Medicare Part B and D premium.

Name of Carrier: _____

I attest that the claim submitted to the Fund Office is accurate and agree to provide Coordination of Benefits ("COB") information to the Fund and to follow the applicable COB rules under the Fund. If any claims are processed and paid by the Fund for which my eligible dependents has or had coverage which would be considered primary, I will be responsible to reimburse the Fund for any and all such claims and agree to be liable for all such claims. I also agree to immediately notify, in writing, the Fund Office if any statement made herein is no longer true or correct. I also agree that if reimbursements or coverage is provided by the Fund for myself or my spouse or dependents who are not otherwise eligible (or if I do not notify the Fund Office that the Medicare Part B and D Premiums are being reimbursed through another carrier), this may be considered fraud or intentional misrepresentation and the coverage/reimbursements under the Fund may be rescinded or terminated to the extent permitted by law.

Participant's Signature: _____Date: _____