Benefit Fund for Hospital and Health Care Employees — Philadelphia and Vicinity
1319 Locust Street • Philadelphia, PA 19107-5405
215.735.5720 • 800.531.1199 • Fax 215.985.9232

Statement of Claim for Medicare Reimbursement

Please PRINT all information.

Your Name ______________________ Birth date ____________ Phone number ____________

Spouse's Name ______________________ Birth date ____________ Phone number ____________

Address ______________________________ Apt. No. ____________

City ______________________ State ________ Zip ________ - ________

Date of retirement ______________________________

Where working at retirement ______________________________
Name of Institution *City* *State*

Social Security Number ______________________ ☐ Male ☐ Female

Wages for ________ *Fill in the year for which you are reporting wages* $ ______________

Check one box only: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

If this claim is for reimbursement of Medicare premiums, fill in this section

Your Social Security Number ______________________________

Place a check mark in the box for each month you have paid.

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Spouse's Social Security Number ______________________________

Place a check mark in the box for each month you have paid.

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Member's signature ______________________________ Date ______________

You must attach a copy (keep the original for your records) of the Form 1099 you receive from the Social Security Administration for each year you are claiming reimbursement. If you are claiming reimbursement for more than one year, you must fill out one of these forms for each year. Return all paperwork to:

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Health Care Employees --
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