Application for Reimbursement of Medicare Premiums *(For Part B Coverage)*

Name: _____ ***Social Security #:*** _____

Address: _____ ***Phone #:*** _____

_____

_____

I certify that:

~ I am not receiving reimbursement for the monthly premium deducted from my Social Security check from any other source.

~ I am a retiree of: *(check one)*
___ City of Warren General Employees Retirement System
___ City of Warren 401A Retirement System
___ City of Warren Police & Fire Retirement System

~ I am currently married to _____ a retiree of: *(check one)*
___ City of Warren General Employees Retirement System
___ City of Warren 401A Retirement System
___ City of Warren Police & Fire Retirement System

~ I am the beneficiary of _____ a deceased retiree of: *(check one)*
___ City of Warren General Employees Retirement System
___ City of Warren 401A Retirement System
___ City of Warren Police & Fire Retirement System

~ I agree to notify the City of Warren if any of the above should change

If it is subsequently determined that I did not meet the above criteria, I agree to reimburse the City for monies I received for which I was not eligible:

_____ _____
Signature *Date*

Please provide a copy of the red-white-blue "Medicare Health Insurance" card along with this application to:

City of Warren Police & Fire Retirement System
One City Square, Suite 415
Warren, MI 48093