APPLICATION FOR REIMBURSEMENT
OF MEDICARE PREMIUMS (*FOR PART B COVERAGE*)

Name: _____

Address: _____

_____

Social Security #_____

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
General Employees Retirement System
One City Square, Suite 415
Warren MI 48093-5289