Mamaroneck Union Free School District

Medicare Part B, Retiree Information

Certificate of Eligibility

RETIREE INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Date of Birth: _____

Social Security No.: _____

MEDICARE A&B ID #: _____

SPOUSE INFORMATION

Spouse's Name: _____

Date of Birth: _____

Social Security No.: _____

MEDICARE A&B ID #: _____

This is to certify that in order to be eligible for Medicare reimbursement I am currently on the Mamaroneck UFSD health insurance plan and I am not collecting Medicare reimbursement from any other agency.

Retiree's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____

Before me appeared _____ on this the _____ day of _____

Notary Public _____ Seal: