

APPLICATION FOR MEDICARE PART-B REIMBURSEMENT

Applicant _____

Applicant Social Security Number _____

Street Address _____

City/State/Zip _____

Phone _____ **Date of Birth** _____ **Gender** _____

E-mail _____

Applicant: Please check applicable box Retiree ☐ Spouse ☐ Dependent ☐

If applicant is the Spouse or Dependent, please **provide Name and Social Security number of the Retired BOCES' Employee:** _____

Is Medicare Part B Reimbursement available to the Applicant through any other source?
YES ☐ NO ☐

Please return this completed application, along with the Direct Deposit form, and copies of your Medicare card, and your most recent statement from the Social Security Administration. Mail to:
Eastern Suffolk BOCES, Department of Human Resources, 201 Sunrise Hwy., Patchogue, NY 11772

APPLICANT'S SIGNATURE _____

DATE _____

All reimbursements will be distributed to the Retiree's account (not a spouse's account).

PRESENTATION OF FALSE PROOF IN SUPPORT OF CLAIM ON A POLICY OF INSURANCE IS PROHIBITED BY SECTION 1202 OF THE PENAL LAW.

