

# Medicare Part B Annual Premium Reimbursement Request

## United Nations



Insurance and Disbursement Service, FF-300, 304 East 45<sup>th</sup> St. New York, NY 10017 – Tel:- (212) 963-5804 – EMAIL: [ashi@un.org](mailto:ashi@un.org)

### SECTION 1 – ASHI participant *(Print all information clearly)*

Full Name (LAST, First)	Index Number - Not UID or Pension Number	Retiree Number
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Mailing Address	Personal Email Address
	Telephone Number:

### SECTION 2 - Part B Premiums Claimed

*Please note that this reimbursement claim will not be valid without proof of payment (such as Form CMS-500 – “Notice of Medicare Premium Due”) attached.*

Name (Last, First)	Relationship to Participant	Medicare ID	Coverage period <i>From:                      To:</i>		Monthly Premium Paid

### SECTION 3 - Bank information for EFT payment

*Fill out Section 3 if you are submitting for a reimbursement claim for the first time. If the reimbursement is for spouse only, please note that banking details should be the primary subscriber’s account or a joint account otherwise the claim will be rejected.*

Have your banking details changed?     YES             NO

*If yes, complete the details below and include a voided check for reimbursement into checking accounts.*

Bank Name:	
Account no:  <input type="checkbox"/> Savings <input type="checkbox"/> Checking (only check one)	Routing or ABA #, IBAN or SWIFT Code:

I declare that I will continue to make payments to Medicare for my Medicare Part B coverage and I understand that my claims will be adjudicated as if I had Medicare Part B regardless of my actual Medicare status.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date