

2017 MEDICARE REIMBURSEMENT REQUEST

LEOFF I AND ESCALATOR RETIRED SEATTLE POLICE PENSION FUND MEMBERS ONLY

****NO MEDICARE REIMBURSEMENTS WILL BE PROCESSED UNTIL WE HAVE RECEIVED YOUR NOTARIZED MANDATORY REPORTING AND MEDICAL REPORTING FORMS! ****

Do NOT use this reimbursement form to request Medicare Reimbursement if you already submit requests to our office on a Monthly, Quarterly or Half-Yearly basis.

This form is only for LEOFF I or ESCALATOR retired Seattle Police Pension Fund members who are on MEDICARE. This is for a reimbursement request for premiums you paid out for your Medicare coverage. Reimbursement will only be considered in response to your submitting a claim for your out-of-pocket expenses in 2017.

Medicare Premium, Part B

\$ 109.00* OR \$ _____ x _____ = \$ _____
*Standard Rate (# of months) (TOTAL)

Proof of non-standard rate* must be attached, NO EXCEPTIONS!

Proof can consist of a copy of your 1099SS Benefit Statement (typically mailed in the January after the current year) or a copy of the letter sent in about November (the previous year) with your premium clearly identified.

Proof can also be a copy of your checks/bank statement with the stub portions of each billing included if you are billed directly.

Call Social Security at 1-800-772-1213 to obtain the documentation, if you do not have it in your files.

Name (Please Print) _____

Address _____

(address where check is to be mailed)

City _____ State _____ Zip _____

Phone _____ Email: _____

SIGNATURE _____

Please return this reimbursement form to:
Seattle Police Pension Office, PO Box 94729, Seattle, WA 98124-4729
Fax: 206-386-9075 or email policepension@seattle.gov

Keep a copy for your records! Please allow up to 4-6 weeks for processing. If you have not received your check AFTER that time, please call the Pension Office at 206-386-1286 or email us at: policepension@seattle.gov

RFR