Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1-888–864–8363
Fax: (614) 628–1777
www.op–f.org

MEDICARE PART B REIMBURSEMENT STATEMENT

Complete and return this form to the Ohio Police & Fire Pension Fund (OP&F) to receive a partial reimbursement of your Medicare Part B insurance premium. OP&F will reimburse a portion of your premium provided that you are not eligible to receive this reimbursement from any other source. Regardless of your eligibility for the OP&F health care stipend, reimbursement will begin the month following OP&F's receipt of your fully completed Medicare Part B Reimbursement Statement and Medicare billing statement or a copy of your Medicare card. OP&F will not make retroactive reimbursement payments of the Medicare Part B premium.

Section A: Member Information

Name: First, MI, Last, suffix (Jr. III, etc.)

Street Address / Post office box

City, State, ZIP code

Social Security number

Date of Birth

Home phone ❑ New | Alternate phone ❑ New | Email address ❑ New

Section B: Required documentation

You must attach a copy of your Medicare billing statement or card to this fully completed statement to be eligible for reimbursement.

Section C: Signature and acknowledgement

I, the benefit recipient described in Section A of this Medicare Part B Reimbursement Statement, who, having been duly sworn, represent that I am the person herein described; all statements made and information provided is true and correct to the best of my knowledge; I certify that OP&F is the only entity from which I receive reimbursement of my Medicare Part B premium; I authorize OP&F to recover any reimbursements received by me as a result of false or inaccurate information; and OP&F has the right to independently verify any information or statement made by me in this statement.

Member signature: ▶

Date of signature:

Section D: Notary Public Requirement

The notary public or HOST member in good standing, who witnessed the signature in Section C, must sign in the space provided in this section and affix their seal. State of _____, County of _____, ss:

The foregoing *Medicare Part B Reimbursement Statement* was acknowledged before me by the person named in the foregoing Section A, this _____ day of _____ , 20_____.

Affix Seal here

Notary's signature: ▶

Print name:

My commission expires: