

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.)		Social Security number																					
Street Address / Post office box		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																					
City, State, ZIP code		Date of Birth																					
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Home phone	<input type="checkbox"/> New	Alternate phone	<input type="checkbox"/> New																				
Email address			<input type="checkbox"/> New																				

Section B: Medicare Information

Medicare number (as written on your Medicare card):


I certify that OP&F is the only entity from which I receive reimbursement of my Medicare Part B premium. (Initial here):

Section C: Required documentation

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

Section D: 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:
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Section E: Notary Public Requirement

The notary public or HOST member in good standing, who witnessed the signature in section D, 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: