

**NEW YORK CITY EMPLOYEE BENEFITS PROGRAM  
MEMBERSHIP RECERTIFICATION/PART B REIMBURSEMENT**

**CITY RETIREE INFORMATION (PLEASE PRINT CLEARLY)**

RETIREE SOCIAL SECURITY NUMBER:
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**NAME AND MAILING ADDRESS (PLEASE PRINT CLEARLY)**

LAST NAME:	FIRST NAME:	M.I.	MALE/FEMALE
HOME ADDRESS – NUMBER – STREET:		CITY:	STATE: ZIP CODE:
TELEPHONE NUMBER:	DATE OF BIRTH:	DATE OF RETIREMENT:	AGENCY FROM WHICH RETIRED:
/ /	/ /	/ /	
RETIREMENT SYSTEM:	YEARS IN PENSION SYSTEM:	TITLE AT TIME OF RETIREMENT:	NAME OF UNION/WELFARE FUND:
RECEIVING PENSION CHECK? YES NO	IF YES, PENSION NO.:	NAME OF CURRENT CITY PLAN:	OPTIONAL RIDER: YES NO
MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER LEGALLY SEPARATED			
DATE OF EVENT: / /			

**SPOUSE/DOMESTIC PARTNER INFORMATION (Please Print Clearly)**

SOCIAL SECURITY NUMBER:	LAST NAME:	FIRST NAME:	M.I.
DATE OF BIRTH:	EMPLOYED BY OR RETIRED FROM A NYC AGENCY	EMPLOYMENT STATUS: (CIRCLE ONE)	
/ /	YES NO	NOT EMPLOYED EMPLOYED RETIRED	
NAME & ADDRESS OF CURRENT/FORMER EMPLOYER:	HEALTH COVERAGE OTHER THAN MEDICARE?	IF YES, HEALTH PLAN INFO:	
	YES NO		

**DEPENDENT CHILDREN INFORMATION – LIST ONLY ELIGIBLE DEPENDENTS (Please Print Clearly)**

FIRST NAME	LAST NAME	DATE OF BIRTH	MALE/FEMALE	DISABLED Y/N	FOR DISABLED CHILDREN COVERED BY MEDICARE		
					Medicare Claim No.	Effective Dates Part A	Part B

**MEDICARE INFORMATION – ATTACH COPIES OF MEDICARE CARD(S) (Please Print Clearly)**

FULL NAME	MEDICARE CLAIM NUMBER (S)	EFFECTIVE DATES	
		Hospital Part A	Medical Part B
RETIREE		/ /	/ /
SPOUSE/DOMESTIC PARTNER		/ /	/ /

**PLEASE READ THE FOLLOWING NOTES, THEN SIGN BELOW**

- All eligible persons must sign below and attach Medicare Card photocopies. This form will be returned if it is incomplete.
- Your signature affirms that you have not knowingly made a false statement; that you understand any information supplied may be used by the City to appropriately adjust your health insurance status.

RETIREE SIGNATURE	SIGNATURE DATE	DATE OF DEATH (IF APPLICABLE)
SPOUSE/DOMESTIC PARTNER SIGNATURE	SIGNATURE DATE	DATE OF DEATH (IF APPLICABLE)