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

CITY RETIREE INFORMATION (PLEASE PRINT CLEARLY)

RETIREE SOCIAL SECURITY NUMBER:

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 YES NO	EMPLOYMENT STATUS: (CIRCLE ONE) NOT EMPLOYED EMPLOYED RETIRED

NAME & ADDRESS OF CURRENT/FORMER EMPLOYER:	HEALTH COVERAGE OTHER THAN MEDICARE? YES NO	IF YES, HEALTH PLAN INFO:

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

1. All eligible persons must sign below and attach Medicare Card photocopies. This form will be returned if it is incomplete.
2. 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)