IAFF Local 587 Health Insurance Trust Fund
Medicare Reimbursement Form

(Please print clearly)

Member Information

Full Legal Name	Last 4 of Medicare Number	Date of Birth	
Mailing Address	City	State	Zip
Phone Number	Email Address		

Reimbursement Information

Month/Year	Part "A" Premium	Part "A" Penalty	Part "B" Penalty	Total
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

Total Amount Paid $

- Reimbursements will be paid out for accumulated six month period Jan - Jun and July - Dec.
- Proof of payment: Medicare billing notice, bank statement, receipt or letter from Social Security or Medicare confirming amounts. **medicare.gov/my/premiums/monthly**
- Failure to provide the proper documentation including a completed reimbursement form and proof of payment(s) shall be reason for the reimbursement request to be rejected.

Mail, email or fax this completed form with proof of payment to the contact information below

IAFF Local 587 Health Insurance Trust Fund
2980 NW South River Drive Miami, Fl. 33125
Office: 305-425-1938 Fax: 305-633-3935 Email: bookkeeper@healthtrustmaff.org

Signature _____ Date _____

Any person who knowingly and with intent to injure, defraud, or deceive by filing a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.