



MEDICARE VERIFICATION

FC 1638 (10-04-22)

▶ Please complete the following information and return in the enclosed, postage-paid envelope.

Retiree Name (Print Name):	Phone Number:
Spouse/Eligible Domestic Partner Name (Print Name):	Email Address:
Medicare Verification Form Submitted for: <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse/Eligible Domestic Partner	

Check the applicable box:

I am enrolled in Medicare Parts A & B.
 Enclosed are a copy of my Medicare Card and a copy of my Medicare premium statement, which reflects the cost of my Medicare Part B premium.

I am *not* enrolled in Medicare Parts A & B. I am not eligible for Medicare because I did not pay into enough quarters of Medicare coverage while working and I am not eligible for Medicare through my spouse or former spouse. In order to be enrolled in Medicare, I would be required to pay the premium for Part A. **Enclosed is a copy of the Medicare Eligibility Notice that verifies this information.**

Medicare Number:	
Part A begin date:	
Part B begin date:	

Retiree or Spouse/Eligible Domestic Partner Signature

I hereby certify that the above information is true and correctly stated.

Signature: _____

Date: _____

BENEFITS USE ONLY

Process Medicare Verification Form	Additional Comments
1. _____ Update Infor System	
2. _____ Send Medicare Part B reimbursement info to Accounting	
Reimbursement beginning: _____	