USW LOCAL 10-00086 MERCK EMPLOYEES' HEALTH AND WELFARE FUND

MEDICARE PART B QUARTERLY PREMIUM REIMBURSEMENT REQUEST FORM

ELIGIBILITY: **Members Only** who are enrolled in Medicare Parts A and B

SCHEDULE OF BENEFITS:

The ***standard monthly Medicare Part B premium*** will be reimbursed to eligible members on a quarterly basis by the USW Local 10-00086 Merck Employees Health and Welfare Fund. The allowed premium amount will be revised from time to time to correspond to changes made by "Medicare." This form must be completed and signed. **Attach a copy of your Medicare Card** and submit both to your Benefits Administrator:

Benefits Administration Team
RAE Consulting
601 Dresher Road, Suite 201
Horsham, PA 19044
USWHealth@rae-consulting.net
Telephone: [215] 773-0900 Fax: [215] 773-9907

MEMBER INFORMATION:

Name: _____

Address: _____

_____

MERCK Employee ID#: _____

I request to be reimbursed for my Medicare Part B monthly premium (standard premium maximum amount) from the USW Local 10-00086 Health and Welfare Fund. I declare that I will continue to make payments to Medicare for my Medicare Part B coverage and I understand that my claims will be adjudicated as if I had Medicare Part B regardless of my actual Medicare status. I understand the reimbursement to me will be automatically processed as soon as administratively possible following each quarter. I have provided a copy of my Medicare card for proof of eligibility.

_____
Signature Date

[Benefits Administrator Only]

Approval: ____ Yes ____ No _____ _____
Initials **Date**

Revised Form Date: January 2025