If you have questions please contact the City's Insurance Specialist at 616-456-3300

Medicare Supplemental Trust Fund

Reimbursement Application

(Return this page to the City of Grand Rapids)

(This form is to be used only when the retiree purchases a supplement to Medicare through a private insurance company.)

RETIREE NAME **<<FIRST NAME>> <<LAST NAME>>**

RETIREE PHONE NUMBER ____________________

I wish to cancel my Medicare Supplemental Health Care Policy through the City of Grand Rapids effective ____________________,201 at 11:59 P.M. I understand that I cannot purchase the City's insurance at a later date. I also wish to have the following insurance company reimbursed by the Medicare Supplemental Trust Fund pursuant to Sec. 1. 320 of the City Ordinance.

The payments will be billed ( ) Quarterly

POLICY Number: ____

Name of Company: ____

Address: ____

Insurance Company Contact Person: _________________________ Phone: ______________________

I understand that only health plans identified by the retired employee's Contract or Contract Number may be reimbursed. Separate plans identified by a spouse's plan are not covered unless the retired employee is deceased and the spouse is an eligible beneficiary. Payments are made directly to the employee's insurance company, not to the employee. And insurance company may receive up to but not more than 100% of the supplement.

_________________________ _________________________ _______________

Retiree Signature | Spouse Signatute | Date

Approved by: ____

Mary Beth Jelks

For HR use:

The current supplement for: **Fire is $115.00 per month.**

Effective: 4/16

ADDENDUM "B-3"

Created: 8/06, Updated 6/13, Rev. 10/17