Sergeants Benevolent Association

Health and Welfare Fund

MEDICARE ELIGIBLE INFORMATIONAL DATASHEET

Please supply the following information for your Medicare eligible dependents in order to update your SBA prescription benefit. **FAILURE TO SUBMIT THIS FORM WILL MAKE YOU AND YOUR SPOUSE INELIGIBLE FOR SBA HEALTH AND WELFARE BENEFITS**

Member's Name_____ Tax #_____
Social Security#_____-____-_____Medicare Unique ID_____
Date of Birth _____
Date of Medicare Eligibility _____
Current member health plan _____
Do you have any pharmaceutical coverage than the SBA plan? Yes ◯ No ◯
If so, plan name_____
lnsured's name_____

Spouse/Domestic Partner's Name_____
Social Security#_____-____-_____Medicare Unique ID_____
Date of Birth _____
Date of Medicare Eligibility _____
Current member health plan _____
Do you have any pharmaceutical coverage than the SBA plan? Yes ◯ No ◯
If so, plan name_____
lnsured's name_____

Dependent's Name_____
Social Security#_____-____-_____Medicare Unique ID_____
Date of Birth _____
Date of Medicare Eligibility _____
Current member health plan _____
Do you have any pharmaceutical coverage than the SBA plan? Yes ◯ No ◯
If so, plan name_____
lnsured's name_____

Attach PDF copies of your Medicare cards along with this form

SUBMIT