SOUTH COUNTRY CENTRAL SCHOOL DISTRICT AFFIDAVIT OF MEDICARE STATUS

***OFFICE USE ONLY*:**
Individual or Family: _____
Reimb Amount:$________
1099 Received: Yes / No

RETIREE NAME: ______________________ SPOUSE NAME: ______________________

ADDRESS: ______________________________________ ☐ **CHECK HERE IF NEW ADDRESS**

____

____

PHONE NUMBER: ____________________ E-Mail Address: ______________________

EMERGENCY CONTACT: ________________________ PHONE NO.: ________________

What Medical coverage do you currently have with the South Country Central School District?
Individual ☐ or Family ☐

Date you became, or will become, Medicare Eligible______________.

Date your spouse became, or will become, Medicare Eligible____________.

Are you covered under any other Health Insurance other than Medicare and the SSEHP Plan? __________
If yes, Name of Insurance Company: ____

Do you receive Medicare Reimbursement from any other source? NO________ YES________
If yes, please indicate the source: ____

Does your spouse receive Medicare Reimbursement from any other source? NO________ YES________
If yes, please indicate the source: ____

*Retiree Signature _____________________________ *Spouse Signature __________________________
Date: ______________ Date:______________

*IF BEING SIGNED BY SOMEONE OTHER THAN APPLICANTS, PROVIDE A COPY OF THE POWER OF ATTORNEY

IT IS YOUR RESPONSIBILITY TO ENSURE THAT YOU ARE NOT RECEIVING MEDICARE REIMBURSEMENT FROM TWO EMPLOYERS

Presentation of false proof in support of claim on a policy of insurance is prohibited by section 1202 of Penal Law

Please return this form to:
South Country Central School District
Attention: Amanda Coppola
189 N. Dunton Avenue
East Patchogue, NY 11772