

PSSU LOCAL UNIT HEALTH AND WELFARE FUND

Health Reimbursement Arrangement (HRA)

RETIREE VERIFICATION FORM

Please complete this form and return with Health Reimbursement Arrangement (HRA) Claim Form.

Name (Please Print)

Social Security

Address

City

State

Zip

Phone Number

- 1) Date of your retirement: _____
- 2) What was your age on the date of your retirement? _____
- 3) How many years of credited service with Bucks County (per Bucks County Employees Retirement System)? _____
- 4) How many years have you been a member of the PSSU Collective Bargaining Unit?

- 5) How many of the years of credited service were immediately prior to retirement?

- 6) If you are eligible for Medicare, have you enrolled in Medicare Part A and Part B?

- 7) If you are not yet eligible for Medicare, are you enrolled under your Spouse's group health plan if such coverage is available to you or any other group health plan available to you on account of your active employment? _____

Signature

Date