SUFFERN CENTRAL SCHOOL DISTRICT
45 MOUNTAIN AVENUE
HILLBURN, NEW YORK 10931

Please complete this form and return with a copy of your Medicare card(s) by February 20, 2026, to:

Suffern Central School District
Attn: Christina Bennin, Benefits Office
45 Mountain Avenue
Hillburn, NY 10931

Please provide your primary address and notify us of any future address changes.

☐ New Address

NAME: _____

ADDRESS: _____

PHONE: _____

EMAIL: _____

DATE OF BIRTH: _____ MEDICARE #: _____

SPOUSE'S NAME: _____

DATE OF BIRTH: _____ MEDICARE #: _____

Please provide the name, address and phone number of an emergency contact in the event that we are unable to contact you.

NAME: _____

ADDRESS: _____

PHONE: _____

EMAIL: _____

THIS IS TO CERTIFY THAT I AM ELIGIBLE FOR MEDICARE REIMBURSEMENT FROM THE SUFFERN CENTRAL SCHOOL DISTRICT. THIS IS TO CERTIFY THAT I AM NOT RECEIVING REIMBURSEMENT FROM ANY OTHER AGENCY.
I ALSO AGREE TO NOTIFY THE DISTRICT WITHIN 10 DAYS OF ANY DISQUALIFYING EVENT, SUCH AS DIVORCE, DEATH OF A SPOUSE, OR ANY OTHER EVENT WHICH DISQUALIFIES ME OR MY SPOUSE FROM RECEIVING REIMBURSEMENT OF THE MEDICARE PREMIUM.

SIGNATURE: _____ DATE: _____

SPOUSE'S SIGNATURE: _____ DATE: _____