



Instructions Medicare Part A Reimbursement Request Form

Please read the instructions below to complete the attached form properly. Please use this reimbursement form for all Medicare Part A reimbursement requests commencing **on or after January 1, 2007**. If you have any questions about the status of your reimbursement request, please contact us at www.acclarisonline.com or call the Acclaris Reimbursement Center toll-free at 1-866-203-9358, Monday through Friday (excluding New York Stock Exchange holidays) between 8:00 A.M. and 8:00 P.M. Eastern Standard Time to speak with a Customer Service Representative.

Who May Request Medicare Part A Reimbursement

- You must be a Textron Retired Employee.
- **The pension plan reimburses retirees who are charged a Medicare Part A deductible for inpatient services, provided you are not reimbursed by a supplemental insurance policy.**
- You must have attained age 65 at the time of hospitalization and be receiving a monthly Textron pension under one of the following plans:
 - Systems Division Bell Aerospace Textron Hourly Union and Non-union
 - Bell Helicopter Hourly Union
 - Bell Helicopter Amarillo Hourly Union and Non-union
 - Bell Helicopter Hourly Non-union
- Reimbursement is for the Retiree only, dependents are not eligible.
- Other restrictions may apply. In the event of a conflict the provisions of the plan document(s) will prevail.

What Expenses May Be Reimbursable

- Medicare Part A deductible for inpatient services.

How To Apply for Reimbursement

- You must submit a completed claim form.
- One of the following must be included with the completed claim form:
 1. Medicare Summary Notice
 2. Medicare Benefit Notice
 3. Hospital statement

Please note: The deductible must be clearly identifiable

Forms that are incomplete or missing proper documentation will not be processed and will be returned.

Make a copy of this form and all related documents for your files and mail to:

**Acclaris Reimbursement Center
PO Box 20571
Tampa, FL 33622-0571**

Or fax forms to: 1-813-830-7900

Medicare Part A Reimbursement Request Form

About You Please Print

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Last Name First Name Middle Initial Social Security Number

Address City State Zip Telephone Number

Hospital Information

Hospital Name Date (s) of Hospital Stay Date Released

Expense Information

Inpatient Deductible: \$ _____

This request must be accompanied by one of the following items:

- Medicare Summary Notice
- Medicare Benefit Notice
- Hospital Statement

Retiree Signature and Date

I certify that I am eligible for Medicare Part A reimbursement and the expenses incurred are accurate. I further declare that these expenses have not previously been reimbursed to me nor will I seek reimbursement from any other plan covering this benefit.

I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information is guilty of a crime and may be liable for substantial civil penalties. I hold Acclaris, Inc. its affiliated companies, officers and employees harmless for payment of any ineligible expenses presented in such a matter.

Signature

Date



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