Medicare Part D Prescription Drug Premium Reimbursement Form – NYCT Retirees & Eligible Dependents

HR-BEN-412

Section 1 - Information and Instructions

The purpose of this form is for UnitedHealthcare Medicare Rx for Groups (PDP) members to request reimbursement of the extra Medicare Part D premium, known as Income-Related Monthly Adjustment Amount (IRMAA), which is assessed under federal requirements.

Please note:

1) **To obtain reimbursement you must submit with this form proof of premium payment as follows:**
   a) **Members receiving Social Security**: your 1099 form that shows the premium paid for Medicare Part D in the previous year.
   b) **Members not receiving Social Security:** a canceled check, money order, or premium advice statement for one month's Medicare Part D premium payment.
2) **The MTA Business Service Center (BSC) will issue annual reimbursements within 30 days of receipt of your signed form and proof of premium payment.**
3) **Application for reimbursement must be renewed annually.**

Please return a signed copy of this form along with proof of payment to the Business Service Center:

Fax: 212-852-8700; **Email:** bscservice@mtabsc.org; **Mail:** MTA Business Service Center, 333 W. 34th Street, New York, NY 10001

Walk-in Center: 180 Livingston Street, 6th Floor, Brooklyn, NY, Monday-Friday, 8:30 a.m. to 5 p.m.

If you have any questions, please contact the BSC at 646-376-0123 or bscservice@mtabsc.org.

Please notify the BSC if you change your address or other personal information.

Section 2 – Retiree Information (See reverse for dependent information)

Print Name	Last First M.I. Suffix	BSC ID
		Pass #
Street Address (must be your current address, **not** a PO Box)		
City	State	Zip Code
Phone (H)	Phone (Cell)	Email

Section 3 – Retiree Authorization for Reimbursement Through Direct Deposit

You have the option of receiving your reimbursement by check or through direct deposit. Please provide the following information if you wish to authorize the deposit of your reimbursement into a checking and/or savings account in the bank of your choice. A direct deposit can be made to any commercial or savings bank in the Greater New York Metropolitan area that is a member of the ACH Clearing House System (check with your bank before enrolling). Direct deposit can also be made to a credit union account.

Bank Name	
Bank Address	
Bank Account Name	
Bank Account Number	ABA Routing Number

Section 4 - Authorization and Documentation

Attachment to this application: Proof of payment of Medicare Part D Prescription Drug Premium.

I hereby certify that to the best of my knowledge the information contained herein is true and correct. I authorize the Social Security Administration to furnish to the MTA Business Service Center any information relating to my enrollment under Medicare. I agree to refund to the MTA any payment made to which I was not eligible.

Retiree Signature	Date	SSN Last 4 Digits

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Section 5 – Eligible Dependent Information

Please complete for each Medicare-eligible person who is applying for reimbursement of the Medicare Part D Prescription Drug Premium. (If more than one dependent, complete page 3.)

Print Name	Last First M.I. Suffix	SS# (last 4)
		Relationship
Street Address (must be your current address, **not** a PO Box)		
City	State	Zip Code
Phone (H)	Phone (Cell)	Email

Section 6 – Dependent Authorization for Reimbursement Through Direct Deposit

You have the option of receiving your reimbursement by check or through direct deposit. Please provide the following information if you wish to authorize the deposit of your reimbursement into a checking and/or savings account in the bank of your choice. A direct deposit can be made to any commercial or savings bank in the Greater New York Metropolitan area that is a member of the ACH Clearing House System (check with your bank before enrolling). Direct deposit can also be made to a credit union account.

Bank Name	
Bank Address	
Bank Account Name	
Bank Account Number	ABA Routing Number

Section 7- Dependent Authorization and Documentation

Attachment to this application: Proof of payment of Medicare Part D Prescription Drug Premium.
I hereby certify that to the best of my knowledge the information contained therein is true and correct. I authorize the Social Security Administration to furnish to the MTA Business Service Center any information relating to my enrollment under Medicare. I agree to refund to the MTA any payment made to which I was not eligible.

Dependent Signature	Date	SSN Last 4 Digits

Section 8 – Additional Dependent Information

Please complete for each Medicare-eligible person who is applying for reimbursement of the Medicare Part D Prescription Drug Premium. (See reverse if more than two dependents.)

Print Name	Last First M.I. Suffix	SS# (last 4)
		Relationship
Street Address (must be your current address, **not** a PO Box)		
City	State	Zip Code
Phone (H)	Phone (Cell)	Email

Section 9 – Additional Dependent Authorization for Reimbursement Through Direct Deposit	
You have the option of receiving your reimbursement by check or through direct deposit. Please provide the following information if you wish to authorize the deposit of your reimbursement into a checking and/or savings account in the bank of your choice. A direct deposit can be made to any commercial or savings bank in the Greater New York Metropolitan area that is a member of the ACH Clearing House System (check with your bank before enrolling). Direct deposit can also be made to a credit union account.	
Bank Name	
Bank Address	
Bank Account Name	
Bank Account Number	ABA Routing Number

Section 10 – Additional Dependent Authorization and Documentation		
Attachment to this application: Proof of payment of Medicare Part D Prescription Drug Premium. *I hereby certify that to the best of my knowledge the information contained therein is true and correct. I authorize the Social Security Administration to furnish to the MTA Business Service Center any information relating to my enrollment under Medicare. I agree to refund to the MTA any payment made to which I was not eligible.*		
Dependent Signature	Date	SSN Last 4 Digits