United Nations **Nations Unies**

INSURANCE and DISBURSEMENT SERVICE
Room FF-335, United Nations, New York, NY10017
Tel. No.: (212) 963-5811 Fax No.: (917) 367-1670 Email: ashi@un.org

IMPORTANT CHANGE TO YOUR UN AFTER-SERVICE HEALTH INSURANCE (ASHI) COVERAGE

28 November 2012

To: Medicare Part B Reimbursement Recipients

From: Mario Tuason, Chief, Health and Life Insurance Section, IDS

Subject: 2013 Medicare Part B Reimbursement Procedures

Dear ASHI Participant,

Our records indicate that you and/or your eligible dependents are enrolled in Medicare Part B and are reimbursed by the UN for the premiums. This is to inform you that we have now simplified the reporting requirements for continued reimbursement in 2013 for those paying the standard minimum amount.

A. If you and/or your eligible dependents will be paying the *standard* minimum Medicare Part B monthly premium amount of $104.90 starting 1 January 2013

You will no longer be required to submit an annual reimbursement form. The UN will automatically update your records and reimburse you with this amount. Once a year, we will randomly contact retirees receiving the Medicare B subsidy and request them to provide information supporting their enrolment. Failure to do so may result in termination of the Medicare Part B premium reimbursement. Therefore, please retain all relevant information documenting your continued enrolment in Medicare B, including a record of payment of the premiums.

B. If you and/or your eligible dependents will be paying a *non-standard* Medicare Part B monthly premium amount other than $104.90 starting 1 January 2013

You will be required to submit the "Medicare Part B Annual Premium Reimbursement Request" form as well as proof of payment of the amount paid. You may use the form printed on the reverse side. Please complete and sign it, attaching the supporting information, and mail or fax them to the above address/number. You may also email a scanned version to ashi@un.org. Failure to submit the request and proof of payment will result in a reimbursement of only the standard minimum amount of $104.90 for 2013.

Please be reminded that you are responsible for the timely payment of your Medicare premiums. Failure to pay on time may result in the termination of your Medicare coverage. Not only will your Medicare Part B reimbursement cease, your claims will continue to be adjudicated by your insurance plan as if you have Medicare. No exceptions or waivers will be made for your failure to maintain your Medicare coverage.

If you or your spouse will become eligible for Medicare Part B in 2013, the procedures for submitting a request for reimbursement can be found at our website, www.un.org/insurance including the form and other relevant information regarding the UN's insurance programme.

You can also write us with any queries via email at ashi@un.org. **Please ensure that you include your full name and index or retiree number.**

My team and I would like to extend our best wishes to you and your family during the holiday season.

Medicare Part B Annual Premium Reimbursement* Request
United Nations

Insurance and Disbursement Service, FF-300, 304 East 45th St. New York, NY 10017 – Tel: (212) 963-5813 – EMAIL: ashi@un.org

**Please note that the normal reimbursement method will be by decreasing the amount of your ASHI contribution. This form should be used to provide evidence of your Medicare premiums payments. If your payment amount is greater than your ASHI contribution, please also complete section 3 below.*

SECTION 1 – ASHI participant *(Print all information clearly)*

Full Name(LAST, First)	Index Number	Retiree Number

Mailing Address	Personal Email Address
	Telephone Number:

SECTION 2 - Part B Premiums Claimed

Please note that this reimbursement claim will not be valid without proof of payment (such as Form CMS-500 – "Notice of Medicare Premium Due") attached.

Name (Last, First)	Relationship to participant	Medicare ID	Coverage period *From:*	*To:*	Monthly Premium Paid

SECTION 3 - Bank information for EFT payment

Please note that payment will only be effected in the event your Medicare premium is greater than your ASHI contribution.

Bank Name:	
Account no:	Routing or ABA #, IBAN or SWIFT Code:

I declare that I will continue to make payments to Medicare for my Medicare Part B coverage and I understand that my claims will be adjudicated as if I had Medicare Part B regardless of my actual Medicare status.

_____ Signature

_____ Date