NYSHIP
New York State Health Insurance Program

2014 MEDICARE PART B INCOME RELATED ADJUSTMENT AMOUNT (IRMAA) REIMBURSEMENT APPLICATION

Please complete this form ONLY if you and/or your dependent was subject to the 2014 Medicare Part B Income Related Adjustment Amount (IRMAA). Submit this completed form and required documentation to:

NYS Department of Civil Service
Employee Benefits Division
Attn: IRMAA Processing
Albany, NY 12239

ENROLLEE INFORMATION

Name: Last, First, MI

_____
(Last) (First) (MI)

Social Security Number (last 4 digits)

XXX-XX- __ __ __ __

Enrollee Mailing Address

Address_____Apt.#_____

City_____State_____Zip Code_____

☐ check here if this is a change of address

Daytime Telephone Number (with area code)

DEPENDENT INFORMATION

If you are applying for reimbursement for your dependent, you must complete the dependent information below.

Name of Dependent (Last, First, MI)

_____
(Last) (First) (MI)

Social Security Number (last 4 digits)

XXX-XX- __ __ __ __

DOCUMENTS REQUIRED FOR REIMBURSEMENT OF IRMAA

Enrollee (include **both** of the following)

1.	copy of Social Security Administration (SSA) letter stating your 2014 Medicare Part B premium includes an income-related monthly adjustment amount
2.	copy of Form SSA-1099 **<OR>** proof of direct payments and billing statements for all premiums paid directly to CMS in 2014 (for Railroad Retirement participants: copy of Form RRB-1099, Copy C)

Dependent (include **both** of the following)

1.	copy of Social Security Administration (SSA) letter stating your 2014 Medicare Part B premium includes an income-related monthly adjustment amount
2.	copy of Form SSA-1099 **<OR>** proof of direct payments and billing statements for all premiums paid directly to CMS in 2014 (for Railroad Retirement participants: copy of Form RRB-1099, Copy C)

By completing and signing this application, I certify that I was or my dependent was required to pay the Medicare Part B Income Related Adjustment Amount (IRMAA) and no reimbursement is occurring from another source.

Enrollee Signature:_____ Date: _____

Print Name: _____

IRMAA reimbursement for both the enrollee and dependent will be issued to the enrollee ONLY. In order for the Employee Benefits Division to speak with the dependent regarding the application for the IRMAA, we must have a HIPAA Release Form (EBD-543) completed and signed by the enrollee.

You are encouraged to submit your request for NYSHIP reimbursement as soon as possible but no later than December 31, 2015. Refunds will be sent as a separate check to your address of record. The refund process will take a minimum of 90-120 days from receipt of documentation.

Medicare Part B Premium Reimbursement From Another Source

Complete the following if you and/or your covered dependent receives full or partial Medicare Part B premium reimbursement from another source, such as you or your spouse's former employer:

Enrollee/Dependent Name	Reimbursement Source	Amount or % (per month)

Personal Privacy Protection Law Notification: The information you provide on this form is requested for the principal purpose of authorizing the use and/or disclosure of protected health information pursuant to 45 CFR 164.508. Failure to provide the information may interfere with our ability to use or disclose protected health information necessary to administer NYSHIP and NYPERL. The information will be maintained by the Director of the Employee Benefits Division, Department of Civil Service, Albany, NY 12239. The information will be used in accordance with Public Officers Law section 96(1), also known as the Personal Privacy Protection Law. For information on the Personal Privacy Protection Law, call (518) 457-9375. If you have any questions regarding this form or your insurance coverage, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m. Monday through Friday.