New York City Office of Labor Relations
Health Benefits Program
nyc.gov/olr

Medicare Part B IRMAA Reimbursement Form

The City of New York Health Benefits Program reimburses Medicare eligible retirees and their Medicare eligible dependents for any Medicare Part B income-related monthly adjustment amount (IRMAA) premiums (excluding any penalties or surcharges) paid during the calendar year. If you and/or your eligible dependent paid a Medicare Part B IRMAA during the calendar year - ***which means more than the standard Medicare Part B monthly premium*** - you may be entitled to an additional reimbursement. Reimbursement will be distributed to you in the same manner in which you receive your pension payments; if you receive direct deposit of your pension payments, your reimbursement will also be made via direct deposit.

Check which year(s) you are applying for reimbursement and provide the required documentation for each year:

☐ **2018** ☐ **2017** ☐ **2016**

Retiree Information:

Name (Last, First, MI):_____

Social Security Number:_____ Address: _____

Phone Number:_____ _____
City State Zip

Eligible Dependent Information:

Name (Last, First, MI):_____

Social Security Number:_____

Required Documentation Checklist:

Please note: Reimbursement requests that do not include both documents for each eligible person for the year(s) indicated above will not be evaluated. Please include the retiree's name and social security number on any eligible dependent's documentation.

Retiree - include all of the following for each year you are applying for IRMAA reimbursement:

- ✓ Copy of Social Security Administration (SSA) notice stating your Medicare Part B premium included an income-related monthly adjustment amount
- ✓ Copy of Form SSA-1099 OR proof of direct payments and billing statements for all premiums paid directly to CMS

Dependent - include all of the following for each year you are applying for IRMAA reimbursement:

- ✓ Copy of Social Security Administration (SSA) notice stating your Medicare Part B premium included an income-related monthly adjustment amount
- ✓ Copy of Form SSA-1099 OR proof of direct payments and billing statements for all premiums paid directly to CMS

Retiree Signature:

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

Signature:_____ Date:_____

Please submit this form, along with all required documents, to:

NYC Health Benefits Program
Attn: IRMAA Unit
40 Rector Street, 3rd Floor
New York, NY 10006

If you need a replacement copy of your IRMAA notice you can obtain one from your local Social Security office, which can be located on the following website: https://www.ssa.gov/onlineservices. This website can also be accessed to request a copy of the SSA-1099.

Please note: Queens Borough Public Library retirees, Brooklyn Public Library retirees, and City University of New York retirees should contact their agency's benefits office if they have questions about this form. Retired NYCTA civilians, with the exception of NYCTA Police Officers, must contact the Transit Authority.

Furthermore, the Medicare Part B/IRMMA reimbursement by the City, pursuant to Section 12-126 of the New York City Administrative Code, of the Medicare Part B premiums actually paid to Medicare by retirees, are excludable from the gross income of the retirees under Section 106 of the Internal Revenue Code.

Please do not staple or tape the submitted documents as all documents will be scanned.

FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT

20XX • PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.
• SEE THE REVERSE FOR MORE INFORMATION.

Box 1. Name	Box 2. Beneficiary's Social Security Number

Box 3. Benefits Paid in 20XX	Box 4. Benefits Repaid to SSA in 20XX	Box 5. Net Benefits for 20XX *(Box 3 minus Box 4)*

DESCRIPTION OF AMOUNT IN BOX 3

Paid by check or direct deposit Medicare Part B premiums deducted from your benefits
Total Additions
Benefits for 20XX

DESCRIPTION OF AMOUNT IN BOX 4

Box 6. Voluntary Federal Income Tax Withheld

Box 7. Address

Box 8. Claim Number *(Use this number if you need to contact SSA.)*

Form **SSA-1099-SM** (1-20XX)

DO NOT RETURN THIS FORM TO SSA OR IRS

Social Security Administration

Date: November 26, 20XX
Claim Number: XXXX-XX-XXX

City N.Y. Retiree
123 Your Home Street
New York, NY 1111-1111

Your Social Security benefits will increase by XX percent in 20XX because of a rise in the cost of living. The premium you pay for Medicare Part B (Medical Insurance) will increase because a Medicare law required some people to pay a higher premium for their Medicare Part B coverage based on their income.

The information in this notice about your premium is for one year only.

How Much Social Security Will I Get?

- Your new 20XX monthly benefit amount before deduction is: $ XX,XXX.XX
- Your 20XX deduction for Medicare Part B premium is: $ XXX.XX
  - $ XX.XX for the standard Medicare premium, plus
  - $ XXX.XX for the income related monthly adjusted amount based on your 20XX income tax return
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January XX, 20XX is: $ X,XXX.XX

Your Medicare Part B Premium

Your Medicare Part B premium for 20XX is the standard Medicare premium, plus any surcharges for late enrollment or re-enrollment, plus an income-related adjusted amount.