

**UBO USE ONLY**

RET/TERM: \_\_\_\_\_ 1<sup>st</sup> Payment Year: \_\_\_\_\_

EE Med Part B: \_\_\_\_\_ PYC's: \_\_\_\_\_

SP/DP Med Part B: \_\_\_\_\_

**(MEMBERS OF TIAA-CREF PENSION SYSTEM)  
APPLICATION FOR MEDICARE PART B PREMIUM REIMBURSEMENT**

**RETIREE INFORMATION:**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**RETIREE INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address: \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

College Retired From: \_\_\_\_\_ Retirement Date: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Domestic Partner Date of Event: \_\_\_\_\_

Do you receive a monthly Lifetime Income Annuity from TIAA-CREF?  Yes  No

Are health insurance premiums withheld from your TIAA-CREF pension check?  Yes  No  No Premium Required

Current New York City Retiree Health Plan: \_\_\_\_\_  Individual  Family Plan

**ATTACH COPY OF YOUR RETIREE HEALTH INSURANCE CARD AND THE SIGNED MEDICARE CARD FOR YOURSELF AND YOUR ELIGIBLE DEPENDENT(S).**

**DEPENDENT INFORMATION**

**SPOUSE/DOMESTIC PARTNER INFORMATION:**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is spouse/Domestic Partner employed or retired from a NYC agency?  Yes  No

Is spouse/Domestic Partner covered on retiree's health plan?  Yes  No

Spouse/Domestic Partner's employment status:  Not Employed  Retired  Employed

Is spouse/Domestic Partner receiving Medicare Part B premium reimbursement through their employer?  Yes  No

**MEDICARE INFORMATION:** Medicare Claim Number Effective Date Part A Effective Date Part B

\_\_\_\_\_

**ADDITIONAL INFORMATION**

**DISABLED DEPENDENT CHILD(REN) INFORMATION:** Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicare Claim#: \_\_\_\_\_ Effective Date Part A: \_\_\_\_\_ Effective Date Part B: \_\_\_\_\_

**BENEFICIARY INFORMATION** (Refer to application instructions for description of beneficiary):

Name: \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**AFFIRMATION:**

Your signature below affirms that you have provided accurate information; that you authorize the Social Security Administration to furnish information relative to your Medicare enrollment; that you understand that information supplied may be used by the City to appropriately adjust your health insurance.

Signature of Retiree: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse/Domestic Partner: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS**  
**Application for Medicare Part B Premium Reimbursement**  
**(Members of TIAA-CREF Pension System)**

**A. ELIGIBILITY**

During those months for which a reimbursement is requested, the retiree must have been:

1. Receiving a monthly Lifetime Income Annuity from TIAA-CREF to satisfy standard health care premium deductions (Interest Only, Minimum Distribution and Transfer Pay Out Annuity are not considered settlement options used to satisfy your health care premium deductions); and
2. Enrolled in and paying premiums for a New York City Health Benefits Plan as the contract holder (premiums must be deducted from your monthly TIAA-CREF pension check); and
3. Enrolled in and paying premiums for Medicare Medical Insurance (Part B), and
4. Your primary residence is within the United States.

**B. SPOUSE/DOMESTIC PARTNER OR DISABLED CHILDREN OF RETIREE**

If a spouse/domestic partner or a disabled dependent is enrolled in Medicare Part B and is covered under an eligible retiree's New York City health plan, Medicare premiums may be reimbursed to the retiree. An application for reimbursement must be completed when adding a spouse/domestic partner and/or disabled child.

**C. HEALTH INSURANCE COVERAGE FOR DISABLED DEPENDENT CHILDREN**

Unmarried children age 26 and older who cannot support themselves because of a disability, including mental illness, developmental disability, mental retardation or physical handicap are eligible for coverage if the disability occurred before the age at which the dependent coverage would otherwise terminate. You must provide medical evidence of the disability.

**D. SURVIVORS OF RETIREES**

Unless a survivor is retired from The City University or a New York City agency, and is eligible for and enrolls in the New York City Health Insurance Program as the contract holder, he/she is not eligible for reimbursement for any month beyond the period of the deceased retiree's eligibility. As a reminder, health insurance benefits for survivors of retirees ceases with the death of the retiree, however, survivor dependents may be eligible for continuation of coverage under COBRA. Also, refer to the PSC-CUNY Welfare Fund website <http://www.pscunywv.org> for information on continuation of coverage under COBRA for supplemental benefits.

**E. GENERAL INFORMATION**

- The City of New York Office of Labor Relations (OLR) – Health Benefits Program processes Medicare Part B reimbursements annually, usually in August, for the previous year at the standard monthly rate. The first payment year will be the year **after** your retirement date, provided you are Medicare-eligible; or the year **after** you become Medicare-eligible. You **do not need to apply annually** for this benefit.
- IRMAA – If you and eligible dependents pay more than the standard monthly rate, you **must apply annually** directly through OLR to obtain full reimbursement of Medicare Part B premiums. Claims must be submitted to OLR following receipt of the standard monthly premium reimbursement. Forms and information regarding IRMAA can be found at: [http://www.nyc.gov/html/olr/html/health/health\\_benefits\\_prog.shtml](http://www.nyc.gov/html/olr/html/health/health_benefits_prog.shtml).
- Your Medicare Reimbursement check will be mailed to the address that appears on your application. Please notify this office of your change in address by completing a Change of Address form. Forms can be obtained by contacting University Benefits Office at 646.664.3350. You do not need to apply for reimbursement each year, however, periodically we will mail out a recertification form requesting you review and update your personal information.
- Medicare does not pay for hospital or other medical expenses outside the U.S. If you plan to travel abroad, consider obtaining additional insurance. Currently, the Health Benefits Program does not process reimbursement for retirees residing outside the US territory.
- The University Benefits Office should be notified of any changes due to death of the retiree, spouse/domestic partner or dependent, changes in marital status or any other change which may impact payment of reimbursement for premiums of Medicare Part B.
- A beneficiary is a person, other than yourself, who has been designated by you, to be the administrator or executor of your estate. This beneficiary will be notified of any final Medicare Part B Premium reimbursement upon your death. However, if your spouse/domestic partner is covered as a dependent under your New York City health plan, final payments will be paid to your spouse/domestic partner. To obtain any final payments your beneficiary or surviving spouse/domestic partner must complete and submit a notarized Affidavit, along with a copy of the death certificate and a copy of the will or court document indicating who is the sole beneficiary, the executor/executrix or the administrator/administratrix of your Estate.

**The City University of New York – University Employee Benefits Office**  
**555 West 57<sup>th</sup> Street, 11<sup>th</sup> Floor, New York, NY 10019**