CUNY The City University of New York

UBO USE ONLY
RET/TERM Date: ____________________
EE Med Part B: ____________________
SP/DP Med Part B: ____________________
1st Payment Year: ____________________
PYC's: ____________________

TIAA-CREF MEDICARE-ELIGIBLE RETIREES
APPLICATION FOR MEDICARE PART B PREMIUM REIMBURSEMENT

RETIREE INFORMATION: Social Security Number: _____-_____-_____

Name: ____________________ Date of Birth: ____________________

Address: ____________________
No. and Street Apt. No.

____________________ ( )
City State Zip Code Telephone No.

Email Address: ____________________

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 deductions being withheld from your pension check for retiree health insurance? ☐ Yes ☐ No ☐ No Premium Required
Current New York City Retiree Health Plan: ____________________ Individual or Family Plan (circle one)

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

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 (*Complete for retiree and/or spouse/domestic partner*)**:**

Name	Medicare Claim Number	Effective Date Hospital Insurance (Part A)	Effective Date Medical Insurance (Part B)
Retiree			
Spouse/Domestic Partner			

DISABLED DEPENDENT CHILD(REN) INFORMATION:

Name	Date of Birth	Sex	Medicare Claim Number	Effective Date Hospital Insurance (Part A)	Effective Date Medical Insurance (Part B)

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

Name: ____________________

Address: ____________________
No. and Street Apt. No.

____________________ ( )
City State Zip Code Telephone No.

AFFIRMATION:
Your signature below affirms that you have not knowingly made a false statement; 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 Members of TIAA-CREF Pension System
For Reimbursement of Medicare Medical Insurance (Part B) Premiums

A. ELIGIBILITY

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

1. Receiving a 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).

B. SPOUSE/DOMESTIC PARTNER OR DISABLED CHILDREN OF RETIREE

If a spouse/domestic partner or a disabled dependent is enrolled in Medicare Medical Insurance (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.psccunywf.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.

- 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 646.313.3281. 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/administratix of your Estate.

- When writing to this office about your Medicare Part B reimbursement, please include: Name, last four digits of Social Security Number, Medicare Number for yourself and your eligible dependent(s), Retirement System and number, date of retirement, date of birth for yourself and dependent(s), college from which you retired, home telephone number and the calendar year about which you are inquiring.

The City University of New York – University Employee Benefits Office
395 Hudson Street, 5th Floor, New York, NY 10014