



NYSHIP
New York State
Health Insurance Program

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

Please complete this form only if you and/or your dependent have been subject to the Medicare Part B Income Related Monthly 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 - _ _ _ _

Mailing Address

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Check here if this is a change of address

Year(s) you are applying for reimbursement:

- 2015 2014
 2013 2012

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 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 (for Railroad Retirement participants: copy of Form RRB-1099, Copy C)

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 (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 Monthly Adjustment Amount (IRMAA) and no reimbursement is paid from another source.

Check here if this is an appeal of a prior year IRMAA rate. Proof of payment is required.

Enrollee Signature _____

Date _____

Print Name _____

Telephone () _____

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.

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.