COUNTY OF SUFFOLK
2023 MEDICARE PART B & PART D INCOME RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA) REIMBURSEMENT APPLICATION

ENROLLEE/SURVIVING SPOUSE/DEPENDENT SURVIVOR INFORMATION

EMHP MEMBER ID NUMBER **(7 digit number on your EMHP card)** _____

(Last Name) **(First Name)** **(MI)**

Mailing Address
Street Addess: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone:
Home: _____ **Cell Phone:** _____

SPOUSE/DOMESTIC PARTNER INFORMATION

EMHP DEPENDENT ID NUMBER **(7 digit number on your EMHP card)** _____

(Last Name) **(First Name)** **(MI)**

APPLICATION IS FOR (CHECK ALL THAT APPLY) ☐ **SELF** ☐ **DEPENDENT**

REQUIRED DOCUMENTATION

Please enclose all required documentation for each person for which you are applying.

☐ A copy of the notice from Social Security Adminisration outlining your premium for Medicare Part B including IRMAA, **and**

☐ Proof of Payment for ALL months of Medicare Part B premiums for each eligible person. (See the reverse size of this form for acceptable proofs)

☐ Notarized Certification for Medicare Part B and Part D IRMAA Reimbursement form

SIGNATURE (Required)

By completing and signing this application, I certify that I and/or my dependent(s) were required to pay an Income Related Monthly Adjustment (IRMAA) for Medicare Part B, and were not reimbursed by another source.

Enrollee Signature: _____ **Date:** _____

CERTIFICATION FOR 2023 MEDICARE PART B & PART D
INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA) REIMBURSEMENT

RETIRED EMPLOYEE

Name_____ **Date of Birth** _____ **SS# XXX-XX-**_____
(last four digits)

PLEASE CHECK:

_____ I am receiving Medicare Part B and Part D Income-Related Monthly Adjustment Amount Reimbursement from another source, therefore I understand I am **not eligible** for reimbursement from Suffolk County. If you are receiving a partial reimbursement, please attach proof of partial reimbursement amount received from the other source*.

_____ I certify that I am eligible to receive reimbursement of Medicare Part B and/or Part D Income-Related Monthly Adjustment Amount, and that I am **not eligible for or receiving** reimbursement from any other source*.

Retiree's Signature _____ Date _____

Sworn to before me this ____ day of _____, 20__. _____
Notary Public

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ELIGIBLE SPOUSE/DOMESTIC PARTNER/ SURVIVING SPOUSE OR DEPENDENT SURVIVOR

Name_____ **Date of Birth** _____ **SS# XXX-XX-**_____
(last four digits)

Name of former employer providing health benefits _____

You may be eligible for a Medicare Part B and Part D Income-Related Monthly Adjustment Amount (IRMAA) Premium reimbursement from your former employer as a retiree who has health benefits coverage.

PLEASE CHECK:

_____ I am receiving Medicare Part B and Part D Income-Related Monthly Adjustment Amount Reimbursement from another source, therefore I understand I am **not eligible** for reimbursement from Suffolk County. If you are receiving a partial reimbursement, please attach proof of partial reimbursement amount received from the other source*.

_____ I certify that I am eligible to receive reimbursement of Medicare Part B and/or Part D Income-Related Monthly Adjustment Amount, and that I am **not eligible for or receiving** reimbursement from any other source*.

Spouse/Domestic Partner/Surviving Spouse's Signature _____Date _____

Sworn to before me this ____ day of _____, 20__. _____
Notary Public

If you and/or your spouse/domestic partner is eligible for/or receiving reimbursement from another source (e.g. your spouse is a retiree from a Long Island school district) for your Medicare Part B Premiums and/or Medicare Part B and Part D Income Related Monthly Adjustment Amount, then Suffolk County will not reimburse any Medicare premiums. In addition, if you and/or your spouse/domestic partner are **NOT enrolled in the Suffolk County Medicare Prescription Drug Plan, you and/or your spouse/domestic partner will NOT be eligible for reimbursement of Medicare Part D Income-Related Monthly Adjustment Amount (IRMAA) Premiums.*

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CERTIFICATION FOR 2023 MEDICARE PART B & PART D (IRMAA) REIMBURSEMENT MUST BE COMPLETED, SIGNED, NOTARIZED AND RETURNED TO THE ADDRESS BELOW IN ORDER TO PROCESS YOUR APPLICATION. A COPY OF YOUR PHOTO ID WILL NOT BE ACCEPTED.

Suffolk County Employee Benefits Unit
P. O. Box 6100
Hauppauge, NY 11788