Medicare A, B & D* Premium Reimbursement Claim Form
Request for Reimbursement

Complete form in full – Incomplete forms will be returned unprocessed

Company Code: B04941

Name of Claimant _____SSN _____

Mailing Address _____New Address?_____

Relationship to PCCD Retiree_____Name of Retiree _____

Year of Peralta Retirement: _____Union Affiliation at time of Peralta Retirement_____

Daytime Phone_____ Email address_____

Submit this claim form and one of the documents listed below for calendar year: _____

What type of documentation is required/acceptable?	How often is documentation required?
Medicare billing statement/Notice of Premium Payment Due and proof of payment	Documentation is required quarterly. Generally, those who choose to pay premiums by check or charge are billed by CMS, a Medicare agent**.**
Monthly STRS statement	Upon attainment of age 65 and once a year thereafter. If your amount changes, you are expected to notify us within 30 days of the effective date.
The Social Security Statement to verify the deduction amount	Upon attainment age 65 and once a year thereafter. Your premium amount is announced by the SSA/Medicare in December to affect January premium. If your amount changes, you are expected to send us notification within 30 days of the effective date.
Federal Tax form SSA 1099 (issued annually by the Social Security Administration)	Annually, but not later than March 30 following the claim year.

I certify that the information provided on this form is accurate and:

1. I am retired from the Peralta Community College District or am the spouse or domestic partner of a retiree;
2. I am not reimbursed from another employer's plan - all expenses reimbursed to me under this program will not be reimbursed to my dependents or me by any other means, per Internal Revenue Code 105;
3. I am either a current member of the Kaiser Permanente Senior Advantage Plan through Peralta or I am enrolled in the District's Self-Funded insurance plan (currently administered by Trustmark);
4. I am aware that if my Direct Deposit Authorization is not already on file or needs to be updated I will need to contact CBIZ for instructions.
5. The information provided is accurate and if there is a change I will notify the District within 30 days;
6. I understand that my participation is subject to audit.
7. I understand that reimbursements are scheduled for ten calendar days after the end of each month for prior month eligibility.
8. I understand that reimbursements submitted after the March 30 deadline may be denied and I can file an appeal in accordance with Section 7.1 Claims Procedures as noted in the Plan Document.
9. I understand that I can download a personal copy of the Medicare SPD from the Benefits Office webpage: http://web.peralta.edu/benefits or contact the Benefitce Office for a personal copy mail.

Signature _____ **Date** _____

Attach Proof of Expense and Send Completed Medicare Premium Claim Form To:

CBIZ HCM 2797 Frontage Road NW; Suite 2000; Roanoke, VA 24017

Email cbizflex@cbiz.com

Fax (800) 584-4185

Due to privacy regulations, PCCD cannot obtain this information on your behalf. You can obtain a copy of your annual benefits statement by calling 800-772-1213 or you can download a copy from www.SSA.gov.