



UBO USE ONLY

Retirement Date: _____
 EE Med Part B: _____
 SP 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.

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City State Zip Code Telephone No.

College Retired From: _____ Retirement Date: _____

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

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

Are deductions being withheld from your pension check for retiree health insurance? Yes No

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 any other source? 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			

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)

HEALTH PLAN CHANGES: (Complete only if you changed your health plan within the last 12 months)

Indicate your previous health insurance carrier: _____

Indicate if coverage was individual or family: _____

Indicate period of coverage under previous plan: _____

Indicate your current health insurance carrier: _____

Indicate if coverage is individual or family: _____

BENEFICIARY INFORMATION:

Name: _____

Refer to application instructions for description of beneficiary.

Address: _____

No. and Street

Apt. No.

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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
TIAA-CREF Retiree Applications/Recertification Form
For Reimbursement of Medicare Medical Insurance (Part B) Premiums

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 pension); and
3. Enrolled in and paying premiums for Medicare Medical Insurance (Part B).

SPOUSE/DOMESTIC PARTNER OR DISABLED DEPENDENT 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.

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.

ACTIVE EMPLOYEES

Eligibility for active employees has been restricted by recent Federal legislation.

No active employees or their dependents are eligible for Medicare Part B reimbursement regardless of age or disability, with one exception:

Medicare reimbursement will be provided, after the first twelve months of Medicare coverage, for active employees or their dependents that receive Medicare Disability benefits because of permanent kidney failure. Documentation of Medicare coverage for the condition described must be submitted with this form.

GENERAL INFORMATION

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. New applications may take up to six (6) months to be processed.

Your Medicare Reimbursement check will be mailed to the same address that appears on your application. Please notify this office in writing if your home address changes.

Medicare does not pay for hospital or other medical expenses outside the U.S. If you plan to travel abroad, consider obtaining additional insurance.

Please contact this office if the retiree or eligible dependent(s) has died.

A beneficiary is a person, other than yourself, who has been designated by you, to be the administrator or executor/executrix of your estate. This beneficiary will be notified of any final Medicare Part B Premium reimbursement upon your death.

When writing to this office about your Medicare Part B reimbursement, please include: Name, 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
535 East 80th Street, 4th Floor, New York, NY 10075