



Medicare Premium Request for Reimbursement



Name _____ Daytime phone _____

Address _____ M/Care # _____

City, State, Zip _____ SSN _____

A. FREQUENTLY ASKED QUESTIONS

Where shall I send my annual verification?

Send future Medicare Statements directly to:

Benefit Dynamics
C/o Pension Dynamics
2300 Contra Costa Blvd., Suite 400
Pleasant Hill, CA 94523-3955

Why can't the District obtain Medicare B premium amounts directly from the SSA or Medicare?

Due to privacy regulations, PCCD district personnel cannot obtain information without authorization from the benefactor. SSA provides an annual benefits statement directly to you confirming premium amounts. They will also provide verification upon request by calling 800-772-1213.

Isn't the amount the same for all retirees?

No. The premium amount is determined by Medicare and varies based on each individual taxpayer's eligibility.

B. DOCUMENTATION REQUIREMENT

Type of Documentation Attached	What type of documentation is required?	How often is documentation required?
	Medicare quarterly billing statement and proof of payment	Documentation is required <u>quarterly</u> . 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 <u>once a year thereafter</u> . 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 <u>once a year thereafter</u> . 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.

C. ELIGIBILITY CRITERIA

CHECK the appropriate boxes/SIGN below/ATTACH this form to proof of payment

I am retired from the Peralta Community College District or am the spouse or domestic partner of a Peralta Community College District retiree-**IF YOU DO NOT CHECK THIS BOX, you are ineligible for the reimbursement program**

I am not reimbursed from another employer's plan -all expenses reimbursed to me under this program will not be reimbursed to me or my dependents by any other means, per Internal Revenue Code 105.

I am attaching proof of expense to this form

CHECK one of the following based on your Peralta medical coverage

I am enrolled in the District's Self-Funded insurance plan (currently administered by CoreSource).

or

I am a current member of the Kaiser Senior Advantage Plan through Peralta.

I certify that the above is correct and complete and that reimbursements are scheduled at the end of each quarter (April, July, October, & January). I further understand that my participation is subject to audit.

Signature _____ Date _____

**Attach Proof of Expense and Send or Fax Completed Form To:
Benefit Dynamics C/O Pension Dynamics Corporation**

2300 Contra Costa Blvd. Suite 400 Pleasant Hill, CA 94523-3955 ** Phone (925) 956-0514 ** Fax (925) 956-0534