Medicare B Letter (Age 65) Supporting Form

HR-BEN-031a

Section 1 - Information and Instructions

The purpose of this form is to apply for a Medicare Part B Reimbursement. In order to obtain a reimbursement you must sign and date this application. **You must also submit with your application a copy of your Medicare card (the red, white and blue card) and a copy of your Form SSA-1099 issued by the Social Security Administration**.

Once a retiree enrolls in Medicare Part B, attains age 65 or is disabled as defined by the Social Security Administration, the member may be entitled to a partial or full refund of their monthly Medicare Part B premiums based upon health plan in which they are enrolled.

1. To be eligible for Medicare Part B reimbursement a retiree must meet **all** of the following conditions:
   A. Receiving a pension from NYCERS, MaBSTOA or MTA Bus.
   B. Enrolled in a City or MTA New York City Transit or MTA Bus health plan.
   C. Enrolled in Medicare Part B (medical insurance).
   D. Paid Medicare premiums in the year in which applying for reimbursement.
   E. Employee must not be receiving Medicare Part B reimbursement from another source.
2. To obtain reimbursement, review and make corrections as needed.
3. If your application is not signed and does not include your Medicare card and Form SSA-1099, it will be returned and may delay processing of your reimbursement.
4. Medicare Part B reimbursement ceases at the end of the month in which the retiree dies.
5. Please notify the MTA Business Service Center if you change your address.
6. Reimbursement will be mailed **approximately 3 months** from the receipt of your completed application.
7. You will receive a confirmation of your returned Medicare Part B reimbursement application.

Please fax a signed copy of the form to 212-852- 8700 or e-mail a signed copy of the form to bscservices@mtabsc.org .

If you have any questions, please contact MTA Business Service Center (BSC) at 646-376-0123 or bscservices@mtabsc.org .

Section 2 – Employee/Retiree Information

Print Name	Last	First	M.I. Suffix		BSC ID
Agency (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ Civilian	☐ HQ Police	Department
	☐ LI Bus	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	
Street Address						
City				State		Zip Code
Phone (H)		Phone (W)				E-mail

Section 3 - Declaration

I declare that the statements contained in this application are to the best of my knowledge and belief, true and correct and that I have not knowingly and willfully made a false statement or given information which I know to be false.

Your Date of Birth	Your Date of Retirement
Your Date of Disability	Number of Months
Your Health Insurance Provider	
Medicare "Part B" Date	

Section 4 - Claiming a Spouse

If claiming a spouse, complete this section.

Spouse's Name	Spouse's SSN
Spouse's Date of Birth	Medicare "Part B" Date
Spouse's Signature	Date

Section 5 - Authorization

I authorize the Social Security Administration to furnish to the MTA Business Service Center any information relating to my enrollment under Medicare. I agree to refund to the MTA any payment made to which I was not eligible.

Employee Signature	Date	SSN Last 4 Digits

Print Form