HUMAN RESOURCES & ORGANIZATIONAL DEVELOPMENT

Request for Quarterly or Annual Reimbursement Of Medicare Part B Premium Form

Instructions: This form is to request Medicare Part B reimbursement on a quarterly or annual basis. Eligibility requirements include: 1) you must be a retiree or spouse of the Contra Costa Community College District (CCCCD) and 2) you must have been enrolled in a District sponsored medical plan during the time when receiving Medicare Part B reimbursement. **Please Note:** Surviving spouses are ONLY eligible for Medicare Part B reimbursement for 6 months following the date of death of the retiree. In order to receive the reimbursement complete the reimbursement form below and provide the forms as requested. If your Reimbursement amount changes you must inform Pension Dynamics (address below) the reimbursement vendor. The Medicare Part B reimbursement form is available throughout the year at the CCCCD website. Go to www.4cd.edu select "Human Resources" select "Benefits" and select "Retirees."

Retiree First and Last Name		**Spouse First and Last Name (if applicable)**	
Retiree - Social Security #	**Retirement Date**	**Spouse - Social Security Number (if applicable)**	
Mailing Address	**City**	**Zip Code**	**Phone Number**

Current Health Plan: (Select One)	[ ] Anthem EPO [ ] Anthem HMO [ ] Kaiser Senior Advantage [ ] Anthem Medicare Plan

MEDICARE PART B PREMIUM REIMBURSEMENT FOR THE CALENDAR YEAR	
(√) **Check One**	**I have enclosed one of the following documents for reimbursement verification:**
	Social Security statement showing the amount of the monthly Medicare Part B premiums and when the payments will begin. The form and documentation needs to be submitted every January or anytime the premium amount changes.
	Medicare quarterly billing statement and proof of payment. The form and documentation needs to be submitted every January or anytime the premium amount changes.
	A copy of the monthly Cal STRS statement(s) indicating Medicare Part B premiums deducted from your Cal STRS retirement check. The form and documentation needs to be submitted every January or anytime the premium amount changes.
	A copy of Form SSA-1099 from Social Security which indicates the Medicare B premium payments for the previous calendar year.

Submit to:	PENSION DYNAMICS COMPANY, LLC - Flexible Benefits Department, 2300 Contra Costa Boulevard, Suite 400, Pleasant Hill, CA 94523-3955 Or by fax: 844-859-7309 Or by e-mail: benefits@pensiondynamics.com.
Questions:	Any questions: (925) 956-0514. Breanne Hill Account Representative
Deadline:	**Quarterly Reimbursement:** Claims must be submitted no later than December 31st for the previous calendar year. For example: 2015 claims due by 12/31/16 **Annual Reimbursement:** Claims must be submitted no later than December 31st for the previous calendar year.
Checks:	**Quarterly Reimbursement:** Reimbursement checks are issued on a quarterly basis at the end of each quarter (April, July, October, and January). Claims submitted during the quarter will be paid at the next quarterly check run. A new claim is required each calendar year. **Annual Reimbursement:** Reimbursement checks are issued within 45 days.

Rep Unit	[ ] United Faculty [ ] Local 1 [ ] Management Council [ ] Surviving Spouse		
Requesting:	[ ] Quarterly Reimbursement [ ] Annual Reimbursement	**Retirement:**	[ ] Year

I certify that I: 1) am a retiree of CCCCD or a spouse\domestic partner of a deceased retiree, 2) am enrolled in a qualifying Medicare coordinated plan through CCCCD and 3) am requesting Medicare Part B reimbursement on a quarterly or annual basis. I certify the information provided is accurate and if there is a change in this status I will notify the District.

Retiree or Surviving Spouse Signature	**Date**

Contra Costa Community College District
500 Court Street, Martinez, California 94553
925.229.1000 Fax: 925.229.2490 www.4cd.edu

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