



Medicare A, B & D* Premium Reimbursement Claim Form
Request for Reimbursement
Complete form in full – Incomplete forms will be returned unprocessed

Company Code: YGT

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: **2023 ONLY**

What type of documentation is required/acceptable?	How often is documentation required?
Medicare billing statement/Notice of Premium Payment Due <u>and</u> 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. <i>If your amount changes, you are expected to notify us within 30 days of the effective date.</i>
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. <i>If your amount changes, you are expected to send us notification within 30 days of the effective date.</i>
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 currently an enrolled member of one of the following: Kaiser Senior Advantage Plan through SISC, Anthem MAPD or United American with Anthem PDP coverage.
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 Navia Benefit Solutions 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 Benefits Office for a personal copy mail.

Signature _____ Date _____

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

Navia Benefit Solutions PO Box 53250 Bellevue WA 98015

Email: customerservice@naviabenefits.com

Fax (425) 451-7002

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.