San Joaquin County Employees' Retirement Association

6 S. EL DORADO ST, STE 400 STOCKTON, CA 95202-2804 Tel: (209) 468-2163 • Fax: (209) 468-0480

TO: San Joaquin County Employees' Retirement Association
Attention: Medicare B Enrollment

FROM: Retiree Name ______________________________ (Medicare B Eligible Retiree)

SUBJECT: Participation in 2012 Medicare B Retirement Program

KEY

Medicare B Beneficiaries who file an individual tax return with income:	Medicare B Beneficiaries who file a joint tax return with income:	Total monthly Medicare B premium amount for each participant:
$85,000 or less	$170,000 or less	**$99.90**
Above $85,000 up to $107,000	Above $170,000 up to $214,000	**$139.90**
Above $107,000 up to $160,000	Above $214,000 up to $320,000	**$199.80**
Above $160,000 up to $214,000	Above $320,000 up to $428,000	**$259.70**
Above $214,000	Above $428,000	**$319.70**

PLEASE TYPE OR PRINT IN INK.

ENROLLEES

For 2012, please initiate the Medicare Part B Reimbursement from my Sick Leave Balance as indicated below:

For myself: **Name:** ______________________________ **$** ____________

For Spouse/ and/or qualified Dependent: **Name:** ______________________________ **$** ____________

Name: ______________________________ **$** ____________

TOTAL **$** ____________

SIGNATURE

I certify under penalty of perjury that the foregoing information on the Medicare B premium that I will be paying is true and correct. I understand and agree that once enrolled, the enrollees named above must remain in the Medicare B Premium Reimbursement Program through the end of the calendar year UNLESS and enrollee becomes ineligible for or otherwise discontinues Medicare B coverage. I understand and agree that I must notify SJCERA immediately upon termination of Medicare B coverage for any of the enrollees named above. If I fail to notify SJCERA, I understand that SJCERA is required to collect from me any reimbursement payments to which I am not entitled plus a processing fee.

By signing this form, I agree that I will not make any legal claim of any kind against SJCERA, its staff and advisors, should my participation in this program result in unexpected tax liability to me, including interest and penalties. I understand that my ability to participate in this program is voluntary and a valuable benefit for which I am willing to sign this waiver of all claims.

Send this certification and a signed copy of each enrollee's Medicare card.

Payee / Primary Enrollee Signature	Date