San Joaquin County Employees' Retirement Association

Medicare Part B Reimbursement Form

Instructions: Complete this form annually to participate in the Medicare Part B Premium Reimbursement Program. Submit your completed form and attached Social Security notices (if applicable) by January 2 to SJCERA (address below) for reimbursement in February. Forms received after January 2 will receive reimbursement prospectively.

Retiree Name: _____ Social: XXX-XX-_____

1. ☐ **I would like to participate in the Medicare Part B Reimbursement Program**
   Attach a copy of your Social Security notice indicating your premium
2. ☐ **Adjust my reimbursement amount; participant's Medicare Part B premiums have changed**
   Attach a copy of your Social Security notice indicating your premium
3. ☐ **I want to discontinue the Medicare Part B Reimbursement program**

Please initiate the Medicare Part B Reimbursement from my Sick Leave Balance as indicated below.

Medicare Part B Participant	Part B Monthly Premium
Retiree Name: _____	**$** _____
Spouse Name: _____	**$** _____
Qualified Dependent: _____	**$** _____
TOTAL MONTHLY PREMIUM	$_____

I certify under penalty of perjury that the foregoing Medicare Part B premium information is true and correct. I understand and agree that once enrolled, the enrollees named above must remain in the Medicare Part B Premium Reimbursement Program through the end of the calendar year UNLESS an enrollee becomes ineligible for or otherwise discontinues Medicare Part B coverage. I understand and agree that I must notify SJCERA immediately upon termination of Medicare Part 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.

_____ _____

Signature Date

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