San Joaquin County Employees' Retirement Association

Medicare B Reimbursement Open Enrollment Certification

Retiree Name: _____ **Social:** XXX-XX-_____

Email: _____ **Phone Number:** _____

1) ☐ I would like to participate in the Medicare B Reimbursement Program:

- ***Please initiate the monthly Medicare Part B Reimbursement from my Sick Leave Balance as indicated below:***
  - Retiree Name: _____ $ _____
  - Spouse Name: _____ $ _____
  - Qualified Dependent: _____ $ _____

2) ☐ I want to discontinue the Medicare B Reimbursement program.

Include a copy of the notice from Social Security for your premium cost for either Selection 1 or 2

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 an enrollee becomes ineligible 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.

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.

_____ _____

Signature Date

Send this certification and a copy of each enrollee's Social Security:

Email to contactus@sjcera.org Or
San Joaquin County Employees' Retirement Association (SJCERA);
220 E. Channel Street; Stockton, CA 95202