UBO USE ONLY
Retirement Date:______________
EE Med Part B:______________
SP Med Part B:______________
1st Payment Year ______________
PYC's:______________________

TIAA-CREF MEDICARE-ELIGIBLE RETIREES
APPLICATION FORM FOR MEDICARE (Part B) REIMBURSEMENT

RETIREE INFORMATION: Social Security Number: ______-_____-______

Name: ____ Date of Birth:__________________________

Address:____
No. and Street Apt. No.

____ (______)______________
City State Zip Code Telephone No.

College Retired From:____________________________ Retirement Date:______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner Date of Event:________

Currently Receiving Monthly Pension Income from TIAA-CREF: ☐ Yes ☐ No
Are deductions being withheld from your pension check for retiree health insurance? ☐ Yes ☐ No
Current New York City Retiree Health Plan:_______________________Individual or Family Plan (circle one)

PLEASE ATTACH A COPY OF YOUR RETIREE HEALTH INSURANCE CARD AND THE MEDICARE CARD FOR YOURSELF AND YOUR ELIGIBLE DEPENDENT(S).

SPOUSE/DOMESTIC PARTNER INFORMATION: Social Security Number: _______-_____-______

Name: ____ Date of Birth:_______________

Is spouse/Domestic Partner employed or retired from a NYC agency? ☐ Yes ☐ No
Is spouse/Domestic Partner covered on retiree's health plan? ☐ Yes ☐ No
Spouse/Domestic Partner's employment status: ☐ Not Employed ☐ Retired ☐ Employed
Is spouse/Domestic Partner receiving reimbursement through any other source? ☐ Yes ☐ No

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MEDICARE INFORMATION (Complete for retiree and/or spouse/domestic partner):

Name	Medicare Claim Number	Effective Date Hospital Insurance (Part A)	Effective Date Medical Insurance (Part B)
Retiree			
Spouse			

DEPENDENT CHILD(REN) INFORMATION:

Name	Date of Birth	Sex	Permanently Disabled Yes or No	Medicare Claim Number	Effective Date Hospital Insurance (Part A)	Effective Date Medical Insurance (Part B)

HEALTH PLAN CHANGES: (Complete only if you changed your health plan within the last 12 months)

Indicate your previous health insurance carrier:____
Indicate if coverage was individual or family:____
Indicate period of coverage under previous plan:____

Indicate your current health insurance carrier:____
Indicate if coverage is individual or family:____

BENEFICIARY INFORMATION: Name: ____

Address:____
No. and Street Apt. No.

____ (______)______________
City State Zip Code Telephone No.

AFFIRMATION:
Your signature below affirms that you have not knowingly made a false statement; that you authorize the Social Security Administration to furnish information relative to your Medicare enrollment; that you understand that information supplied may be used by the City to appropriately adjust your health insurance.

Signature of Retiree:____ Date:______________

Signature of Spouse/Domestic Partner___________________________ Date:______________

INSTRUCTIONS
TIAA-CREF Retiree Applications/Recertification Form
For Reimbursement of Medicare Medical Insurance (Part B) Premiums

ELIGIBILITY

During those months for which a refund is requested, the retiree must have been:

1. Receiving a TIAA-CREF Retirement Annuity; and
2. Enrolled in and paying premiums for a New York City Health Benefits Plan as the contract holder (premiums must be deducted from your monthly pension); and
3. Enrolled in and paying premiums for Medicare Medical Insurance (Part B).

SPOUSE/DOMESTIC PARTNER OR DISABLED DEPENDENT OF RETIREE

If a spouse/domestic partner or a disabled dependent is enrolled in Medicare Medical Insurance (Part B) and is covered under an eligible retiree's New York City health plan, Medicare premiums may be reimbursed to the retiree.

SURVIVORS OF RETIREES

Unless a survivor is retired from The City University or a New York City agency, and is eligible for and enrolls in the New York City Health Insurance Program as the contract holder, he/she is not eligible for reimbursement for any month beyond the period of the deceased retiree's eligibility.

ACTIVE EMPLOYEES

Eligibility for active employees has been restricted by recent Federal legislation.

No active employees or their dependents are eligible for Medicare Part B reimbursement regardless of age or disability, with one exception:

> Medicare reimbursement will be provided, after the first twelve months of Medicare coverage, for active employees or their dependents that receive Medicare Disability benefits because of permanent kidney failure. Documentation of Medicare coverage for the condition described must be submitted with this form.

GENERAL INFORMATION

The first payment year will be the year **after** your retirement date, provided you are Medicare-eligible; or the year **after** you become Medicare-eligible. New applications may take up to six (6) months to be processed.

Your Medicare Reimbursement check will be mailed to the same address that appears on your application. Please notify this office in writing if your home address changes.

Medicare does not pay for hospital or other medical expenses outside the U.S. If you plan to travel abroad, consider obtaining additional insurance.

Please contact this office if the retiree or eligible dependent(s) has died.

When writing to this office about your Medicare Part B reimbursement, please include: Name, Social Security Number, Medicare Number for yourself and your eligible dependent(s), Retirement System and number, date of retirement, date of birth for yourself and dependent(s), college from which you retired, home telephone number and the calendar year about which you are inquiring.

The City University of New York – University Employee Benefits Office
535 East 80th Street, 4th Floor, New York, NY 10021