New York City Office of Labor Relations

Health Benefits Program

nyc.gov/olr

Medicare Part B Income-Related Monthly Adjustment Amount (IRMAA) Reimbursement Form

Only complete this form if you and/or your dependent paid more than the standard Medicare Part B premium amount for the year. Please see section III. below for annual standard premium amounts to determine if you paid IRMAA and are eligible for reimbursement.

I. Retiree Information:

Name (Last, First, MI): _____

Social Security Number: XXX-XX- __ __ __ __ Phone Number: _____

Address: _____
City State Zip

II. Eligible Spouse/Dependent Information:

Name (Last, First, MI): _____

Social Security Number: XXX-XX- __ __ __ __

III. Check which year(s) you are applying for reimbursement and provide the required documentation for each year:

☐ **2024 – Apply for this year ONLY if you paid more than $174.70 per month ($2,096.40 annually), excluding penalties.**

☐ **2023 – Apply for this year ONLY if you paid more than $164.90 per month ($1,978.80 annually), excluding penalties.**

☐ **2022 – Apply for this year ONLY if you paid more than $170.10 per month ($2,041.20 annually), excluding penalties.**

IV. Required Documentation Checklist:

Please note: Reimbursement requests that do not include both documents for each eligible person for the year(s) indicated above will not be evaluated. Please include the retiree's name and Social Security number on any eligible dependent's documentation.

Retiree AND eligible Spouse/Dependent – Please enclose all required documentation for each person for which you are applying.

☐ Proof of payment for ALL months of Medicare Part B premiums for each eligible person. Documentation includes:

- ✓ Copy of Form SSA-1099 Social Security Benefit Statement OR proof of direct payments and billing statements for all premiums paid directly to CMS.
- ✓ Copy of Social Security Administration (SSA) benefit notice stating your Medicare Part B premium including the income-related monthly adjustment amount for the year(s) for which you are applying.

Note: If no IRMAA amount is listed on your SSA benefit notice nor included in your Medicare Part B premiums on your Form SSA-1099, you are not eligible for IRMAA reimbursement and you should not complete this form.

V. Retiree Signature:

By completing and signing this form, I certify that I was, or my dependent was, required to pay the Medicare Part B Income Related Monthly Adjustment Amount (IRMAA) and no reimbursement was issued to me or my dependent from any other source.

I understand that reimbursement for both me and my eligible dependent will be distributed to me in the same manner in which I receive my pension payments; if I receive direct deposit of my pension payments, my IRMAA reimbursement will also be made via direct deposit.

Signature: _____ Date: _____

Please submit this form, along with all required documents:

Electronically: https://nycemployeebenefits.leapfile.net

Mail: NYC Health Benefits Program, ATTN: IRMAA
22 Cortlandt Street, 12th Floor
New York, NY 10007

Fax: (212) 306-7373

If you need a replacement copy of your IRMAA notice, you can obtain one from your local Social Security office, which can be located on the following website:
https://www.ssa.gov/onlineservices

(This website can also be accessed to request a copy of your Form SSA-1099.)

Please note: Queens Borough Public Library retirees, Brooklyn Public Library retirees, and City University of New York retirees should contact their agency's benefits office if they have questions about this form. Retired NYCTA civilians, with the exception of NYCTA Police Officers, must contact the Transit Authority.

Furthermore, the Medicare Part B/IRMMA reimbursement by the City of the Medicare Part B premiums actually paid to Medicare by retirees, pursuant to Section 12-126 of the New York City Administrative Code, are excludable from the gross income of the retirees under Section 106 of the Internal Revenue Code.

FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT

20XX • PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.
• SEE THE REVERSE FOR MORE INFORMATION.

Box 1. Name	Box 2. Beneficiary's Social Security Number

Box 3. Benefits Paid in 20XX	Box 4. Benefits Repaid to SSA in 20XX	Box 5. Net Benefits for 20XX *(Box 3 minus Box 4)*

DESCRIPTION OF AMOUNT IN BOX 3

Paid by check or direct deposit Medicare Part B premiums deducted from your benefits
Total Additions
Benefits for 20XX

DESCRIPTION OF AMOUNT IN BOX 4

Box 6. Voluntary Federal Income Tax Withheld

Box 7. Address

Box 8. Claim Number *(Use this number if you need to contact SSA.)*

Form **SSA-1099-SM** (1-20XX)

DO NOT RETURN THIS FORM TO SSA OR IRS

Social Security Administration

Date: November 26, 20XX
Claim Number: XXXX-XX-XXX

City N.Y. Retiree
123 Your Home Street
New York, NY 1111-1111

Your Social Security benefits will increase by XX percent in 20XX because of a rise in the cost of living. The premium you pay for Medicare Part B (Medical Insurance) will increase because a Medicare law required some people to pay a higher premium for their Medicare Part B coverage based on their income.

The information in this notice about your premium is for one year only.

How Much Social Security Will I Get?

- Your new 20XX monthly benefit amount before deduction is: $ XX,XXX.XX
- Your 20XX deduction for Medicare Part B premium is: $ XXX.XX
  - $ XX.XX for the standard Medicare premium, plus
  - $ XXX.XX for the income related monthly adjusted amount based on your 20XX income tax return
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January XX, 20XX is: $ X,XXX.XX

Your Medicare Part B Premium

Your Medicare Part B premium for 20XX is the standard Medicare premium, plus any surcharges for late enrollment or re-enrollment, plus an income-related adjusted amount.