

Dartmouth College
Medicare Part D IRMAA Reimbursement Instructions

If you are a higher-income beneficiary, according to Medicare Income tables, you will pay an Income Related Monthly Adjustment Amount (IRMAA) for your Medicare Part D prescription drug coverage. The adjusted amount is determined by income information you have reported to the IRS in past years.

If you are a member of the Dartmouth College Medicare Supplement (DCMS) Plan, you may be eligible to receive a reimbursement for the prior year's Medicare Part D IRMAA payments you have made. Claims will be reimbursed on an annual basis, according to the required supporting documentation you submit with this form.

Required Supporting Documentation

Please submit the following documentation by February 15, 2019:

- A completed copy of *this Form*. Please provide one form per household.
- The *Social Security Form SSA-1099* issued to you and/or your DCMS covered dependent at the end of the CALENDAR YEAR, as proof of your Medicare Part D IRMAA payment for that year. OR if you are not receiving Social Security, you can submit copies of your monthly invoices from Social Security showing the amount you owed for your 2017 monthly Part D IRMAA.

Please include the Dartmouth College Retiree's name on any eligible dependent's documents you submit. If you need a replacement copy of your *Form SSA-1099* you can obtain one from Social Security office, which can be located on the following website:

<http://www.socialsecurity.gov/onlineservices>

Please note: Reimbursements will be mailed by April 30, 2019. Claims received without the required documentation and/or claims received for IRMAA payments incurred prior to 2016 will not be processed.

Submit the required documentation to:

Dartmouth College
Office of Human Resources
Attn: IRMAA Reimbursement
7 Lebanon Street, Suite 203
Hanover, NH 03755

Dartmouth College
Medicare Part D IRMAA Reimbursement Claim Form
(Complete all sections and attach required documentation)

Section 1 **RETIREE INFORMATION** (please print clearly)

NAME: _____
FIRST MI LAST

SSN: _____

COVERED DEPENDENT: (if enrolled in the DCMS plan)

NAME: _____
FIRST MI LAST

SSN: _____

Section 2 **ADDRESS**

MAILING ADDRESS:

NUMBER STREET APT.

CITY STATE ZIP

RESIDENCE ADDRESS: (if different than Mailing)

NUMBER STREET APT.

CITY STATE ZIP

Section 3. **REQUIRED DOCUMENTS**

(See Claim Instruction sheet)

The following required documents are included for me as the retiree and my eligible, covered dependent:

_____ SSA form 1099 statement or Social Security/Medicare monthly invoices for Retiree

_____ SSA form 1099 statement or Social Security/Medicare monthly invoices for my dependent

Please note: Reimbursements will be mailed by April 30, 2019. Claims received without the required documentation and/or claims received for IRMAA payments incurred prior to 2018 will not be processed.

Signature

Date