COUNTY OF SUFFOLK

EDWARD P. ROMAINE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HUMAN RESOURCES
EMPLOYEE MEDICAL HEALTH PLAN

JOSEPH LAMBERSON
DIRECTOR

TO: All Medicare Reimbursement Recipients

FROM: Susan J. DiFiore
Employee Benefits Coordinator

SUBJECT: **Medicare Part B Premium Reimbursement**

All Suffolk County retirees, who are Medicare eligible, and are covered under the Employee Medical Health Plan of Suffolk County (EMHP) or HIP HMO offered by the County of Suffolk are eligible to receive a reimbursement for their eligible Medicare Part B premium payments as long as they are not receiving this reimbursement from another source.

If you or your spouse/domestic partner and in some cases, a disabled dependent, are retired from an employer who reimburses for Medicare Part B premiums such as, but not limited to, the MTA, City of New York, Nassau County, Towns, Villages or School Districts, as well as some other agencies or public/private employers, you may be eligible for Medicare Part B Premium Reimbursement from that agency or employer. If **retired employees and/or their spouses/domestic partners are eligible for and/or receiving Medicare Part B premium reimbursement from another source, Suffolk County will not reimburse any Medicare premiums.**

If you are eligible for Medicare Part B reimbursement and are receiving Social Security Disability, you are also eligible to receive Medicare Part B reimbursement as long as you are **not eligible for and/or receiving** reimbursement from another source.

In order to verify that you or your spouse/domestic partner's or eligible dependent's eligibility to receive Medicare Reimbursement, **please complete and sign the reverse side of this memo and return this signed form and a copy of your or your spouse/domestic partner's or eligible dependent's Medicare Card to the Employee Benefits Unit at the mailing address indicated below.**

BEFORE THIS OFFICE CAN PROCEED WITH YOUR MEDICARE PART B PREMIUM REIMBURSEMENT, THE VERIFICATION ON THE REVERSE SIDE MUST BE COMPLETED, SIGNED, NOTARIZED AND RETURNED TO THE SUFFOLK COUNTY EMPLOYEE BENEFITS UNIT.

(Over)

LOCATION:
WILLIAM J. LINDSAY COUNTY COMPLEX
725 VETERANS MEMORIAL HIGHWAY-Bldg. #158

MAILING ADDRESS:
P.O. BOX 6100
HAUPPAUGE, NY 11788-0099

(631) 853-4866
FAX: (631) 853-6396

CERTIFICATION FOR MEDICARE PART B PREMIUM REIMBURSEMENT

RETIRED EMPLOYEE

Name_____ Date of Birth _____SS# XXX-XX-_____SCID _____
(Last four digits) *(Benefit Card #)*

PLEASE CHECK:

_____ I am receiving Medicare Part B Reimbursement from another source, therefore I understand I am **not eligible** for reimbursement from Suffolk County. If you are receiving a partial reimbursement, please attach proof of partial reimbursement amount received from the other source.

_____ I certify that I am eligible for reimbursement of Medicare Part B premiums, and that I am **not eligible for and/or receiving** a reimbursement from any other source.

Retiree's Signature _____ Date _____

Sworn to before me this ____ day of _____, 201__. _____
Notary Public

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ELIGIBLE SPOUSE/DOMESTIC PARTNER/SURVIVING SPOUSE OR ELIGIBLE DEPENDENT

Name_____ Date of Birth _____SS# XXX-XX-_____SCID _____
(Last four digits) *(Benefit Card #)*

Name of former employer providing health benefits _____

You may be eligible for Medicare Part B reimbursement from your former employer as a retiree who has health benefits coverage.

PLEASE CHECK:

_____ I am receiving Medicare Part B Reimbursement from another source, therefore I understand I am **not eligible** for reimbursement from Suffolk County. If you are receiving a partial reimbursement, please attach proof of partial reimbursement amount received from the other source.

_____ I certify that I am eligible for reimbursement of Medicare Part B premiums, and that I am **not eligible for and/or receiving** reimbursement from any other source.

Spouse/Domestic Partner/Surviving Spouse or Dependent Survivor's Signature _____ Date_____

Sworn to before me this ____ day of _____, 20__. _____
Notary Public

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BEFORE THIS OFFICE CAN PROCEED WITH YOUR MEDICARE REIMBURSEMENT, THIS VERIFICATION MUST BE COMPLETED, SIGNED, NOTARIZED AND RETURNED ALONG WITH A COPY OF YOUR OR YOUR SPOUSE/DOMESTIC PARTNER'S OR ELIGIBLE DEPENDENT'S MEDICARE CARD TO:

Suffolk County Employee Benefits Unit
P. O. Box 6100
Hauppauge, NY 11788