COUNTY OF SUFFOLK

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF CIVIL SERVICE/HUMAN
DIVISION OF EMPLOYEE SERVICES

THOMAS MELITO
PERSONNEL DIRECTOR

TO: All Medicare Eligible Participants and Dependents

FROM: Susan DiFiore, Employee Benefits Coordinator

SUBJECT: **Medicare Premium Reimbursement**

All Suffolk County retirees, who are Medicare eligible, and are covered under the Employee Medical Health Plan of Suffolk County (EMHP) or one of the HMOs offered by the County of Suffolk are eligible to receive a reimbursement for their eligible Medicare 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 premiums (Parts B (base and/or income related supplemental through IRMAA) and/or D) 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 Premium Reimbursement from that agency or employer. If **retired employees and/or their spouses/domestic partners are eligible for and/or receiving Medicare premium reimbursement from another source, Suffolk County will not reimburse any Medicare premiums whether or not they actually receive those reimbursements from that other source. Therefore, if you/they are eligible for reimbursement from another source, they should do what is necessary in order to get that reimbursement.**

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

IN ORDER TO VERIFY ELIGIBILITY AND PROCESS YOUR OR YOUR SPOUSE/DOMESTIC PARTNER'S OR ELIGIBLE DEPENDENT'S ELIGIBILITY TO RECEIVE MEDICARE PREMIUM REIMBURSEMENT, YOU MUST COMPLETE AND SIGN THE REVERSE SIDE OF THIS MEMO AND RETURN THIS SIGNED FORM ALONG WITH A COPY OF YOUR AND/OR YOUR SPOUSE/DOMESTIC PARTNER'S AND/OR ELIGIBLE DEPENDENT'S MEDICARE CARD TO THE EMPLOYEE BENEFITS UNIT AT THE MAILING ADDRESS INDICATED BELOW.

SUFFOLK COUNTY'S RIGHT OF RECOUPMENT: If you or your eligible dependent(s) are eligible for Medicare premium reimbursement from your/their former employer and you/they do not apply for same, but instead retain Suffolk County's premium reimbursement, then you or your dependent is responsible to reimbursement Suffolk County all Medicare premiums reimbursed during the time period you or your dependent was eligible for reimbursement from your/their former employer. Failure to reimburse Suffolk County for this overpayment can result in the suspension of health benefits for you, the member, and all of your eligible, enrolled dependents until Suffolk County is paid in full.

Suffolk County reserves the right to verify eligibility for Medicare premium reimbursement in the future of any and all recipients of said reimbursement.

(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 PREMIUM REIMBURSEMENT

RETIRED EMPLOYEE

Name_____ Date of Birth_____ SS# XXX-XX-_____
(last four digits)

PLEASE CHECK:

_____ I am eligible for[1] or receiving Medicare (Part B, IRMAA, and/or Part D) Premium 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, IRMAA and/or Part D) 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 _____ 20___. _____
Notary Public

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ELIGIBLE SPOUSE/DOMESTIC PARTNER/SURVIVING SPOUSE OR ELIGIBLE DEPENDENT

Name_____ Date of Birth_____ SS# XXX-XX-_____
(last four digits)

Name of former employer providing health benefits _____

You may be eligible for Medicare (Part B, IRMAA and/or Part D) premium reimbursement from your former employer as a retiree who has health benefits coverage.

PLEASE CHECK:

_____ I am eligible for[1] or receiving Medicare (Part B, IRMAA and/or Part D) Premium 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, IRMAA and/or Part D) 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 WILL PROCESS YOUR MEDICARE PREMIUM 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. 0. Box 6100
Hauppauge, NY 11788

[1] If you are unsure of your eligibility for reimbursement from your former employer, contact that employer and confirm your eligibility. If you are eligible for reimbursement from that employer, you are NOT eligible for reimbursement from Suffolk County.