

**NEW PALTZ CENTRAL SCHOOL DISTRICT
MEDICARE PART B
INCOME RELATED MEDICARE ADJUSTMENT AMOUNT (IRMAA)**

REIMBURSEMENT APPLICATION FOR 2015 TAX YEAR

Submit this completed form and required documentation by **April 30, 2016**, to:

New Paltz Central School District
Business Office
196 Main Street
New Paltz NY 12561

Questions? Call (845) 256-4010.

Your reimbursement will be sent as a check from the District no later than June 1, 2016.

ENROLLEE INFORMATION

Enrollee Name: Last, First, MI

Social Security Number:

(Last) (First) (MI)

Enrollee Mailing Address

**Daytime Telephone Number
(with area code)**

Address _____ Apt # _____

City _____ State _____ Zip Code _____

e-mail address

☐ Check if this is a change of address

DEPENDENT INFORMATION

If you are applying for reimbursement for your dependent, you must complete the dependent information below.
If your dependent receives reimbursement from his/her former employer, you cannot apply for his/her reimbursement.

Name of Dependent (Last, First, MI)

Social Security Number:

(Last) (First) (MI)

DOCUMENTS REQUIRED FOR IRMAA REIMBURSEMENT

Enrollee (**MUST** include **both** of the following)

1. Copy of Social Security Administration (SSA) letter stating your Medicare Part B premium plus your income-related monthly adjustment amount for tax year **2015**
2. Copy of Form SSA-1099 for tax year **2015** <OR> proof of direct payment (must provide proof of all payments) (for Railroad Retirement participants: copy of Form RRB-1099, Copy C)

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2. Copy of Form SSA-1099 for tax year **2015** <OR> proof of direct payment (must provide proof of all payments) (for Railroad Retirement participants: copy of Form RRB-1099, Copy C)

By completing and signing this application, I certify that I was or my dependent was required to pay the Medicare Part B Income Related Medicare Adjustment Amount and is not receiving reimbursement from another source.

Enrollee Signature: _____ Date: _____