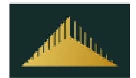
Medicare A, B & D* Premium Reimbursement Claim Form
Request for Reimbursement

Complete form in full – Incomplete forms will be returned unprocessed



A. This reimbursement request is for premiums paid in calendar year: ____________

Name of Claimant ____SSN ____________________

Mailing Address ____

Relationship to PCCD Retiree_________________Name of Retiree____________________________

Year of Peralta Retirement: ____________Union Affiliation at time of Peralta Retirement____________

Daytime Phone___________________________ Email address_______________________________

B. Submit this claim form and one of the documents listed below:

What type of documentation is required/acceptable?	How often is documentation required?
Medicare billing statement/Notice of Premium Payment Due and proof of payment	Documentation is required quarterly. Generally, those who choose to pay premiums by check or charge are billed by CMS, a Medicare agent.
Monthly STRS statement	Upon attainment of age 65 and once a year thereafter. If your amount changes, you are expected to notify us within 30 days of the effective date.
The Social Security Statement to verify the deduction amount	Upon attainment age 65 and once a year thereafter. Your premium amount is announced by the SSA/Medicare in December to affect January premium. If your amount changes, you are expected to send us notification within 30 days of the effective date.
Federal Tax form SSA 1099 (issued annually by the Social Security Administration)	Annually, but not later than March 30 following the claim year.

I certify that the information provided on this form is accurate and:

1. I am retired from the Peralta Community College District or am the spouse or domestic partner of a retiree;
2. I am not reimbursed from another employer's plan - all expenses reimbursed to me under this program will not be reimbursed to my dependents or me by any other means, per Internal Revenue Code 105;
3. I am either a current member of the Kaiser Permanente Senior Advantage Plan through Peralta or I am enrolled in the District's Self-Funded insurance plan (currently administered by CoreSource);
4. My Direct Deposit Authorization is attached or already on file. I understand if I choose not to sign up for Direct Deposit at this time, checks may no longer be an option in the future (see reverse for form).
5. The information provided is accurate and if there is a change I will notify the District within 30 days;
6. I understand that my participation is subject to audit.
7. I understand that reimbursements are scheduled for ten calendar days after the end of each month for prior month eligibility.
8. I understand that reimbursements submitted after the March 30 deadline may be denied and I can file an appeal in accordance with Section 7.1 Claims Procedures as noted in the Plan Document.
9. I understand that I can download a personal copy of the Medicare SPD from the Benefits Office webpage: http://web.peralta.edu/benefits or contact the Benefits Office for a personal copy mail.

Signature ____ **Date** ________________

Attach Proof of Expense and Send Completed Medicare Premium Claim Form To:

Pension Dynamics Company, LLC
2300 Contra Costa Blvd. Suite 400, Pleasant Hill, CA 94523
** Fax (844) 859-7309 ** Email benefits@pensiondynamics.com

Due to privacy regulations, PCCD cannot obtain this information on your behalf. You can obtain a copy of your annual benefits statement by calling 800-772-1213 or you can download a copy from www.SSA.gov.

DIRECT DEPOSIT AUTHORIZATION

Plan Name: ______________________________

Example "ABC Company Flexible Benefit Plan" If you are unsure about your Plan Name please contact your human resources or benefits department.

SECTION 1. EMPLOYEE INFORMATION

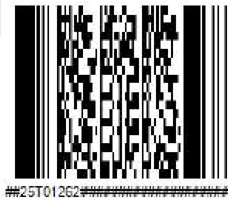
Name ______________________________ Social Security Number ______________

Personal Email Address ______________________ Daytime Phone Number ______________ Evening Phone Number ______________

SECTION 2. TYPE *(Please select one)*

◯ Initiate Direct Deposit ◯ Change Account ◯ Cancel Direct Deposit

SECTION 3. BANK INFORMATION *Please print legibly*



☐ Checking *Provide account information below and attach a copy of a voided check.*

☐ Savings *Provide account information below.*

Bank Routing Number *Nine Digits, starts with 0, 1, 2, 3, or 4.* Bank Name

Checking or Savings Account Number Checking or Savings Account Owner Name

SECTION 4. EMPLOYEE AUTHORIZATION

I acknowledge the following:

If I do not provide a copy of a voided check Pension Dynamics is not responsible for failed bank transmittal due to incorrect banking information. Deposit slips cannot be accepted as the routing numbers are often different on these slips.

My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.

I authorize Pension Dynamics Company LLC to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and / or debit the same to such account.

Direct deposit of my reimbursement accounts shall commence within 2 (two) weeks of receipt of this form. This direct deposit will be for all reimbursement accounts that I have established with Pension Dynamics.

My direct deposit may be terminated by any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, or cancellation of direct deposit by my employer.

I must notify Pension Dynamics immediately if I make any changes to my banking situation. Not doing so can delay my payment greatly.

I will not assume payment has been made to my bank account at any time. I am solely responsible for checking with my bank as to the deposit amount and date of direct deposits made. I am also responsible for any fees my bank may charge for direct deposits.

I understand the information on this form and authorize Pension Dynamics Company LLC to complete my request as indicated:

Employee Signature ______________________________ Date ______________

Submit via - Email: benefits@pensiondynamics.com or Fax: (844) 859-7309

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