Valley Water

MEDICARE PART B PREMIUM REIMBURSEMENT QUARTERLY PAYMENT REQUEST

For the CALENDAR Quarter Ending 03 / 31 / 2021

FC 1646 (10-15-20)
Side 1 of 2

Retiree Information (Please print clearly)	
Retiree Name:	
Retiree's Eligible Spouse/Dependent Name:	
Address 1:	☐ Check here for change of address.
Address 2:	
City/State/Zip:	
Phone No.:	Email:

Please indicate if you pay your Part B premium directly to Medicare Premium Collection Center or if the monthly amount is deducted from your Social Security Check? Check and attach a copy of the Medicare Premium Bill and/or copy of the Social Security letter.

☐ Pay Directly to MPCC* (Attach Premium Bill) ☐ Deducted From Social Security Check (Attach Social Security Letter)

*** If you pay directly to Medicare Premium Collection Center and received a NOTICE OF MEDICARE PREMIUM PAYMENT DUE form CMS-500 send notice to the Accounting Unit with this Form.**

Requested Reimbursement

Requester	First Month	Second Month	Third Month	Total Reimbursement Request
	Jan 2021	Feb 2021	Mar 2021	
Retiree				
Retiree's Eligible Spouse/Dependent				
Total Reimbursement for Medicare Part B Premiums				

Retirees and Eligible Dependent are required to submit to the Benefits Unit a copy of their Medicare Award Notice in order to qualify for reimbursement for Medicare Part B Premium. The yearly Notice of Annual Change in Amount should be sent to the Accounting Unit.

Reimbursable amounts will be paid once a quarter. All requests for payment must be received by the last day of each calendar quarter (March 31, June 30, September 30, and December 31) and payment will be made within 45 days after the end of the quarter. Reimbursement forms not received by the due date will be processed in the subsequent quarter. Reimbursement forms can be obtained by calling the Accounting Unit at (408) 630-2404, or at: www.valleywater.org. (See side 2 for details.)

Return the completed and signed form to:

Santa Clara Valley Water District
General Accounting Unit
5750 Almaden Expressway
San Jose, CA 95118

Signature

I hereby certify that the above information is true and correctly stated.

Retiree sign here: Date:

Accounting Use Only

Vendor No.:	Amount:
Charge Acct.: 11-2553	Invoice No.: 03312021 Medicare Part B
Authorized by:	Date:

Valley Water

MEDICARE PART B PREMIUM REIMBURSEMENT QUARTERLY PAYMENT REQUEST

For the CALENDAR Quarter Ending 06 / 30 / 2021

FC 1646 (10-15-20)

Retiree Information (Please print clearly)	
Retiree Name:	
Retiree's Eligible Spouse/Dependent Name:	
Address 1:	☐ Check here for change of address.
Address 2:	
City/State/Zip:	
Phone No.:	Email:

Please indicate if you pay your Part B premium directly to Medicare Premium Collection Center or if the monthly amount is deducted from your Social Security Check? Check and attach a copy of the Medicare Premium Bill and/or copy of the Social Security letter.

☐ Pay Directly to MPCC* (Attach Premium Bill) ☐ Deducted From Social Security Check (Attach Social Security Letter)

*** If you pay directly to Medicare Premium Collection Center and received a NOTICE OF MEDICARE PREMIUM PAYMENT DUE form CMS-500 send notice to the Accounting Unit with this Form.**

Requested Reimbursement

Requester	First Month	Second Month	Third Month	Total Reimbursement Request
	Apr 2021	May 2021	Jun 2021	
Retiree				
Retiree's Eligible Spouse/Dependent				
Total Reimbursement for Medicare Part B Premiums				

Retirees and Eligible Dependent are required to submit to the Benefits Unit a copy of their Medicare Award Notice in order to qualify for reimbursement for Medicare Part B Premium. The yearly Notice of Annual Change in Amount should be sent to the Accounting Unit.

Reimbursable amounts will be paid once a quarter. All requests for payment must be received by the last day of each calendar quarter (March 31, June 30, September 30, and December 31) and payment will be made within 45 days after the end of the quarter. Reimbursement forms not received by the due date will be processed in the subsequent quarter. Reimbursement forms can be obtained by calling the Accounting Unit at (408) 630-2404, or at: www.valleywater.org. (See side 2 for details.)

Return the completed and signed form to:

Santa Clara Valley Water District
General Accounting Unit
5750 Almaden Expressway
San Jose, CA 95118

Signature	
I hereby certify that the above information is true and correctly stated.	
Retiree sign here:	Date:
Accounting Use Only	
Vendor No.:	Amount:
Charge Acct.: 11-2553	Invoice No.: 06302021 Medicare Part B
Authorized by:	Date:

Valley Water

MEDICARE PART B PREMIUM REIMBURSEMENT QUARTERLY PAYMENT REQUEST

For the CALENDAR Quarter Ending 09 / 30 / 2021

FC 1646 (10-15-20)

Retiree Information (Please print clearly)	
Retiree Name:	
Retiree's Eligible Spouse/Dependent Name:	
Address 1:	☐ Check here for change of address.
Address 2:	
City/State/Zip:	
Phone No.:	Email:

Please indicate if you pay your Part B premium directly to Medicare Premium Collection Center or if the monthly amount is deducted from your Social Security Check? Check and attach a copy of the Medicare Premium Bill and/or copy of the Social Security letter.

☐ Pay Directly to MPCC* (Attach Premium Bill) ☐ Deducted From Social Security Check (Attach Social Security Letter)

*** If you pay directly to Medicare Premium Collection Center and received a NOTICE OF MEDICARE PREMIUM PAYMENT DUE form CMS-500 send notice to the Accounting Unit with this Form.**

Requested Reimbursement

Requester	First Month	Second Month	Third Month	Total Reimbursement Request
	Jul 2021	Aug 2021	Sep 2021	
Retiree				
Retiree's Eligible Spouse/Dependent				
Total Reimbursement for Medicare Part B Premiums				

Retirees and Eligible Dependent are required to submit to the Benefits Unit a copy of their Medicare Award Notice in order to qualify for reimbursement for Medicare Part B Premium. The yearly Notice of Annual Change in Amount should be sent to the Accounting Unit.

Reimbursable amounts will be paid once a quarter. All requests for payment must be received by the last day of each calendar quarter (March 31, June 30, September 30, and December 31) and payment will be made within 45 days after the end of the quarter. Reimbursement forms not received by the due date will be processed in the subsequent quarter. Reimbursement forms can be obtained by calling the Accounting Unit at (408) 630-2404, or at: www.valleywater.org. (See side 2 for details.)

Return the completed and signed form to:

Santa Clara Valley Water District
General Accounting Unit
5750 Almaden Expressway
San Jose, CA 95118

Signature	
I hereby certify that the above information is true and correctly stated.	
Retiree sign here:	Date:
Accounting Use Only	
Vendor No.:	Amount:
Charge Acct.: 11-2553	Invoice No.: 09302021 Medicare Part B
Authorized by:	Date:

Valley Water

MEDICARE PART B PREMIUM REIMBURSEMENT QUARTERLY PAYMENT REQUEST

For the CALENDAR Quarter Ending 12 / 31 / 2021

FC 1646 (10-15-20)
Side 1 of 2

Retiree Information (Please print clearly)	
Retiree Name:	
Retiree's Eligible Spouse/Dependent Name:	
Address 1:	☐ Check here for change of address.
Address 2:	
City/State/Zip:	
Phone No.:	Email:

Please indicate if you pay your Part B premium directly to Medicare Premium Collection Center or if the monthly amount is deducted from your Social Security Check? Check and attach a copy of the Medicare Premium Bill and/or copy of the Social Security letter.

☐ Pay Directly to MPCC* (Attach Premium Bill) ☐ Deducted From Social Security Check (Attach Social Security Letter)

*** If you pay directly to Medicare Premium Collection Center and received a NOTICE OF MEDICARE PREMIUM PAYMENT DUE form CMS-500 send notice to the Accounting Unit with this Form.**

Requested Reimbursement

Requester	First Month	Second Month	Third Month	Total Reimbursement Request
	Oct 2021	Nov 2021	Dec 2021	
Retiree				
Retiree's Eligible Spouse/Dependent				
Total Reimbursement for Medicare Part B Premiums				

Retirees and Eligible Dependent are required to submit to the Benefits Unit a copy of their Medicare Award Notice in order to qualify for reimbursement for Medicare Part B Premium. The yearly Notice of Annual Change in Amount should be sent to the Accounting Unit.

Reimbursable amounts will be paid once a quarter. All requests for payment must be received by the last day of each calendar quarter (March 31, June 30, September 30, and December 31) and payment will be made within 45 days after the end of the quarter. Reimbursement forms not received by the due date will be processed in the subsequent quarter. Reimbursement forms can be obtained by calling the Accounting Unit at (408) 630-2404, or at: www.valleywater.org. (See side 2 for details.)

Return the completed and signed form to:

Santa Clara Valley Water District
General Accounting Unit
5750 Almaden Expressway
San Jose, CA 95118

Signature

I hereby certify that the above information is true and correctly stated.

Retiree sign here: Date:

Accounting Use Only

Vendor No.:	Amount:
Charge Acct.: 11-2553	Invoice No.: 12312021 Medicare Part B
Authorized by:	Date:

MEDICARE PART B PREMIUM REIMBURSEMENT INSTRUCTIONS

FC 1646 (11-25-19)

1. Obtain a copy of form FC 1646 Medicare Part B Reimbursement Quarterly Payment Request. Reimbursement forms can be obtained by going to the District website at **http://www.valleywater.org**. Click on Copyright©Santa Clara Valley Water District at the bottom left corner of the website page or type **http://apps2.valleywater.org/employeelogin/index.shtm** in the Address box. Click on "Click here to access retiree information." The password to enter the restricted area is "**retiree**." Type "retiree" in the box under Enter Password to authorize use of this page. At the Retiree Menu Welcome page click on Medicare Part B Reimbursement form. The form will automatically open as an Adobe PDF file. Save the file to your computer for future submissions. Complete form as instructed below. If in the process you have any questions please call the Accounting Unit at (408) 630-2404, for assistance.

2. On the right top corner next to "For the CALENDAR Quarter Ending," enter the calendar quarter ending date that you are requesting for reimbursement, such as, 3/31/XX, 6/30/XX, 9/30/XX, or 12/31/XX. Please complete one form per Calendar Quarter. Please note that if you make quarterly payments for your Medicare Part B premiums, the District's quarterly reimbursement schedule may differ from your quarterly Medicare payment schedule. The actual reimbursements you receive from the District may be split between quarters.

3. Under Retiree Information please print clearly the Retiree's Name, Address, City/State/Zip, and Phone No. The reimbursement check is made out to Retiree unless Retiree is deceased. If the Reiree is deceased, please write "Deceased" next to Retiree name.

4. If there was a change of address from the prior reimbursement request please check the box next to "Check here for change of address" to alert the District to update your address in our system.

5. Under Current Medicare Insurance Part B Reimbursment please complete the following for you and/or eligible dependents.

    a. First month refers to the first month of the quarter you are requesting reimbursement, such as January, April, July, or October.

    b. Second Month refers to the second month of the quarter you are requesting reimbursement, such as February, May, August, or November.

    c. Third Month refers to the third month of the quarter you are requesting reimbursement, such as March, June, September, or December.

6. Under the Column Total Reimbursement Request enter the total amount requesting reimbursement for the Retiree and for the eligible dependents then add both totals to get the Total Reimbursement for Medicare Part B Premiums.

7. Under the Signature area the Retiree must sign and date the form to certify that the information is true and correctly stated.

8. Please attach proof of payment or deduction. If you send payments to Medicare Premium Collection Center, please attach a copy of your "NOTICE OF MEDICARE PREMIUM PAYMENT DUE" form CMS-500 or copy of Social Security letter.

9. Send completed signed form and attachments to:

    Santa Clara Valley Water District
    General Accounting Unit
    5750 Almaden Expressway
    San Jose, CA 95118