



Medicare Enrollment Verification Form

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
alaska.gov/drb

Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203

Juneau: (907) 465-4460
TDD: (907) 465-2805
Fax: (907) 465-3086

SECTION I. MEMBER INFORMATION

NAME (LAST / FIRST / MI)		SSN OR RIN	
ADDRESS			APARTMENT OR UNIT #
CITY		STATE	ZIP
TELEPHONE NUMBER	EMAIL ADDRESS		

SECTION II. MEDICARE ENROLLMENT INFORMATION

Provide us your Medicare Beneficiary Identifier (MBI) number and effective dates listed on your Medicare card.	
MEDICARE BENEFICIARY IDENTIFIER (MBI)	MEDICARE EFFECTIVE DATE

SECTION III. INCOME RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA)

Certain high-income AlaskaCare members are required to pay a Medicare Part D Income Related Monthly Adjustment Amount, or IRMAA, surcharge.

If you are subject to the IRMAA surcharge, the Division will reimburse you for the full cost of the premium associated with your prescription drug coverage. The Division is prohibited from paying your Medicare Part D IRMAA premium surcharge directly and will instead reimburse you.

Follow the steps below to establish your 2020 IRMAA reimbursement account:

1. Scan, copy, or take a photo of your Social Security letter or Medicare bill that shows what your 2020 Part D IRMAA surcharge will be.
2. Complete the PayFlex Claim form.
3. Mail, fax, or email your completed form and documentation to:

Mail: Division of Retirement and Benefits P.O. Box 110203 Juneau, AK 99811-0203	Fax: (907) 465-3086 Email: doa.drb.irmaa@alaska.gov
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Note: This is an annual process. Reimbursement claims IRMAA surcharges must be submitted within 90 days of the close of that benefit year. For example, claims for reimbursement of 2019 IRMAA surcharges must be received by March 31, 2020. Retroactive reimbursements will not be issued for claims received beyond 90 days after the close of the benefit year.

SECTION IV. SIGNATURE

I have read and understood the requirements to be reimbursed for the Income Related Monthly Adjustment Amount (IRMAA) and that it is my responsibility to complete the process timely. If I fail to complete the IRMAA process as described above, I forfeit any reimbursement that is for the prior benefit year(s).

In completing this form, I acknowledge that a person who knowingly makes a false statement, or falsifies or permits to be falsified, a record of the retirement system in an attempt to defraud the system, is guilty of a class A misdemeanor, which, upon conviction, is punishable by a fine of not more than \$500.00 or by imprisonment for not more than twelve months or both. AS 39.35.670; AS 11.56.210. I also acknowledge that a person who obtains funds and/or benefits by deception may be subject to prosecution for other crimes, including theft, which may be charged as misdemeanors or felonies with potential fines and penalties including imprisonment. I also acknowledge that a person who obtains funds and/or benefits from the system unlawfully may also be required to make restitution.

SIGNATURE	DATE
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