National Elevator Industry Health Benefit Plan
Part D-IRMAA Surcharge Reimbursement Claim Form

YOUR INFORMATION			
Name			Social Security #
Street Address	City	State	Zip Code
Phone #	E-mail Address		

Check List

☐ I am requesting the Part D-IRMAA Surcharge Reimbursement.

☐ I have attached proof of my Medicare Part D-IRMAA Surcharge by the Social Security Administration or Centers for Medicare Services (CMS). **Your proof must show your name and the monthly amount of the Part D-IRMAA Surcharge.**

Direct Deposit Information

Check Applicable ----> ☐ Checking Account or ☐ Savings Account

- **9-DIGIT BANK ROUTING NUMBER:** _____
- **ACCOUNT NUMBER:** _____
- **NAME AND ADDRESS OF BANK TO WHICH PAYMENT IS TO BE MADE**:

  Bank Name _____

  Address _____

  City _____ State ____ Zip Code _____

  Bank Telephone Number (_____) _____

  ****You MUST attach a copy of a blank check marked "VOID"**

YOUR SIGNATURE: _____ **DATE** _____

You may submit this form and your proof of Part D-IRMAA Surcharge via email or mail:

- Email: pension@neibenefits.org
- Mail: National Elevator Industry Benefit Plans
  19 Campus Blvd, Ste 200
  Newtown Square, PA 19073-3288

Documentation received **after December 31** of the calendar year in which you were assessed Part D-IRMAA Surcharges will not be accepted.