Ohio Education Association
PSU & Management Retirees
Medicare Part B Reimbursement Form

In accordance with your contract you are eligible for Medicare Part B reimbursement payments beginning at age 65. For all employees retiring prior to 9/1/12, the maximum monthly reimbursement is 100%. For all PSU employees retiring after 9/01/12, the maximum monthly reimbursement is capped at $175.00. For All Management employees retiring after 9/01/12 and before 9/01/16, the monthly maximum reimbursement is capped at $125.00. For All Management employees retiring after 9/01/16, the monthly maximum reimbursement is capped at $175.00.

The OEA requires a **copy of your current Social Security statement** to be provided with this reimbursement form. You may submit your request for payment quarterly or annually. **All payment requests must be submitted by March 31 for the prior calendar year.**

Please submit your payment requests to:

Ohio Education Association
Attn: Medicare Part B Reimbursements
P.O. Box 2550
Columbus, OH 43216

Retiree Name and Address:

Name: _____

Address: _____

_____

For use with Quarterly Payments

Dates	Amount	Payable After
Jan-Mar		Mar 31
Apr-June		June 30
July-Sept		Sept 30
Oct- Dec		Dec 31

For Use with Annual Payment

Dates	Amount	Payable after Dec 31, Submit By Mar 31st of the Following Calendar Year
Jan-Dec		

For Office Use Only: (Form Updated April 2019)

Approved by _____ Date _____

Approved by _____ Date _____

Acct #	CC	DOL	AMOUNT
2440	000	SC020	

Staff Education Association Retirees VEBA

PO Box 641072, Pittsburgh, PA 15264-1072
Phone – (412) 325-2805, Toll Free – (866) 520-9174, Facsimile – (412) 325-2801

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM FOR RHRA CLAIMS REIMBURSEMENTS

Advantages of ETF RHRA Claims Reimbursement Payments:

- ❑ **Avoids mail delays.**
- ❑ **Eliminates danger of your check being stolen or lost.**
- ❑ **Eliminate a special trip to the bank.**

We request that you accept this authorization of sending RHRA Claim Reimbursements directly to your bank account. Please take advantage of this feature, please complete the following information and return this form to the SEARV Administrative Office listed above.

BANK NAME:

_____

BANK ADDRESS:

_____

_____

BANK TRANSIT ROUTING NUMBER:

_____

TYPE OF ACCOUNT:

[ ] Checking **[ ] Savings**

ACCOUNT NUMBER: _____

I hereby authorize the ongoing RHRA Claim Reimbursements sent to the bank account shown above. Such RHRA Claim Reimbursements will be made periodically, unless I choose to terminate this agreement in writing.

_____

Print Name

_____ _____ ___/___/___

Participant Signature **Date**

Retiree Healthcare Reimbursement Account(RHRA) Reimbursement Claim Form

SEARV RHRA

Name (Last, First, Middle Initial)

Address (Street)

Address (City, State, Zip) ☐ Check Here if New Address

E-Mail Address

Phone Number (Including Area Code)

Reimbursement requests must be submitted by MARCH 31st for prior year expenses

Monthly Self-Pay Contributions ARE NOT Eligible Expenses

Date Expense Incurred (mm/dd/yyyy)	Name of Service Provider (If Applicable)	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate EOB(s), bill(s), or receipt(s) and submit with this claim form.		**Total Healthcare Expense Claim**		**$**

***Return Form along with EOB(s), bill(s), or receipt(s) to, NEW MAILING ADDRESS:**

SEARV
PO Box 641072
PITTSBURGH PA 15264-1072

Read Carefully: The undersigned SEARV Participant certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the RHRA Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. RHRA may require reimbursement of claims subsequently determined to be in-eligible. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim that is provided by the undersigned. The undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan if the payment has been reimbursed by another plan.

SEARV Participant's Signature

Date