State of New Jersey
Income Related Monthly
Adjustment Amount (IRMAA) Retiree Reimbursement Account

A separate claim form is REQUIRED for you and/or your spouse. How to file a claim:

- **Online**: Log into mynjbenefitshub.nj.gov or use the MyChoice Mobile App to submit your claim electronically.
- **Via email, fax or mail**: Fill out your form electronically and submit via email, fax, or mail.
- **Email**: SONJclaims@mychoiceaccounts.com
- **Mail**: MyChoice Accounts, MSC-100535, PO Box 105168, Atlanta, GA 30348-5168
- **Fax**: (855) 883-8542

Instructions for filling out this form:

Complete each section in its entirety. If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

A Expense Type *(Indicate either Medicare D only or Medicare B/D and retiree or spouse)*

B Number of months eligible for and seeking reimbursement *(select one based on Medicare Effective Date)*

C Modified adjusted gross income

SECTION 1: YOUR INFORMATION

RETIREE SOCIAL SECURITY NUMBER (NO DASHES): 3 2 3 1 9 2 1 0 0 3

COMPANY NAME: STATE OF NEW JERSEY IRMAA

RETIREE LAST NAME: S M I T H

HOME ZIP CODE: 9 0 0 1 2

EMAIL: SSMITH@ACME.ORG

DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES): 9 1 9 1 2 4 3 1 0 9

SECTION 2: YOUR HEALTH CARE EXPENSES

A **EXPENSE TYPE**

☐ RETIREE MEDICARE PART B/D
☐ RETIREE MEDICARE PART D
☐ SPOUSE MEDICARE PART B/D
☐ SPOUSE MEDICARE PART D

B **CLAIM START DATE (MM/DD/YY)**: 0 1 0 1 2 1

CLAIM END DATE (MM/DD/YY): 1 2 3 1 2 1

DATE: 0 1 0 1 2 0 2 1

To ensure your claim is submitted successfully, you must submit one of the following with this form:

☐ A copy of the cost-of-living adjustment (COLA) letter sent by Social Security Administration in 2020, or

☐ A copy of the first two pages of your 2019 Federal Income-tax return

You must also include:

☐ A copy of your 2021 Social Security Form SSA-1099, or

☐ A copy of your 2021 Form RRB-1099 (if in the Railroad Retirement system)

If you did not receive Form SSA-1099, you can submit alternative proof of your Medicare Part B or D payments:

☐ A copy of invoice with canceled check

☐ Statement with canceled check

State of New Jersey IRMAA Claim Form

Use only CAPITAL LETTERS, completely fill in and use only blue or black ink.

Email: SONJclaims@mychoiceaccounts.com

Mail: MyChoice Accounts, MSC-100535, PO Box 105168, Atlanta, GA 30348-5168 **Fax:** (855) 883-8542

SECTION 1: YOUR INFORMATION

RETIREE SOCIAL SECURITY NUMBER (NO DASHES)

COMPANY NAME

STATE OF NEW JERSEY IRMAA

RETIREE LAST NAME

HOME ZIP CODE

EMAIL

DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR EXPENSES

EXPENSE TYPE

☐ RETIREE MEDICARE PART B/D ☐ SPOUSE MEDICARE PART B/D

☐ RETIREE MEDICARE PART D ☐ SPOUSE MEDICARE PART D

NUMBER OF MONTHS ELIGIBLE FOR AND SEEKING REIMBURSEMENT (SELECT ONE):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

FIRST DAY OF CALENDAR YEAR FOR REIMBURSEMENT

0 1 0 1 2 0 2 1

LAST DAY OF CALENDAR YEAR FOR REIMBURSEMENT

1 2 3 1 2 0 2 1

Annual Modified Adjusted Gross Income (MAGI) Last Calendar Year

Select the checkbox next to the surcharge amount which you are eligible for. If eligible for B & D, select a surcharge box for both B & D. If only eligible for D, only select the surcharge for D.

Filing Single	Married Filing Joint	Married Filing Separately (MFS)	Monthly Part B Surcharge	Monthly Part D Surcharge
$88,000 or less	$176,000 or less	Not applicable	☐ $00.00	☐ $00.00
Over $88,000 to $111,000	Over $176,000 to $222,000	Not applicable	☐ $59.40	☐ $12.30
Over $111,000 to $138,000	Over $222,000 to $276,000	Not applicable	☐ $148.50	☐ $31.80
Over $138,000 to $165,000	Over $276,000 to $330,000	Not applicable	☐ $237.60	☐ $51.20
Over $165,000 to < $500,000	Over $330,000 to < $750,000	Over $85,000 to < $412,000	☐ $326.70	☐ $70.70
$500,000 and above	$750,000 and above	$412,000 and above	☐ $356.50	☐ $77.10

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free.
- Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.

I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.

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31756 IRMAA Claim Form