# MEDICARE PART B PREMIUM REIMBURSEMENT QUARTERLY PAYMENT REQUEST

**For the CALENDAR Quarter Ending 03 / 31 / 2025**

FC 1646 (12-02-24)



**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 2025 | Feb 2025 | Mar 2025 | |
| 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) 630-2872, 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.: 03312025 Medicare B |
| Authorized by: | Date: |

# MEDICARE PART B PREMIUM REIMBURSEMENT INSTRUCTIONS

FC 1646 (02-23-24)

1. **Complete the e-form version of FC 1646 Medicare Part B Reimbursement Quarterly Payment Request** by visiting https://www.valleywater.org/valley-water-retirees-information. If in the process you have any questions, please call the Accounting Unit at (408) 630-2872 for assistance.

2. Please complete one form per Calendar Quarter. Please note that if you make quarterly payments for your Medicare Part B premiums, Valley Water's quarterly reimbursement schedule may differ from your quarterly Medicare payment schedule. The actual reimbursements you receive from Valley Water may be split between quarters.

3. Under Retiree Information, please type 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 Retiree 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 Valley Water to update your address in our system.

5. Under Current Medicare Insurance Part B Reimbursement, 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. Please attach proof of payment or deduction. If you send payments to Medicare Premium Collection Center, please attach a copy of your "Medicare Premium Bill" or copy of Social Security letter.

   To attach proof of payment, click on the "Submit & Sign" button found on the lower right side of the form.

8. Click on "Upload PDF document" > Then "Click Here to Upload" > Select file to upload > "Upload" form > Hit "Continue."

   Click on the "Finalize & Submit" button found on the lower right side of the form to e-sign your form.

9. Under the Signature area, the Retiree must sign and date the form to certify that the information is true and correctly stated. To e-sign your form:

   To create your e-Signature > Type in your full name and email address. **Important**: **Double-check the accuracy of your email address**; **the system will not alert you if the address is incorrect**. Select one of the Signature Type radio buttons.

10. Check the I agree box > Apply Signature; click on the "Finalize & Submit" button found on the lower right side of the form.

    Your e-form will automatically be sent to Christina Madden for approval.

# MEDICARE PART B PREMIUM REIMBURSEMENT
## QUARTERLY PAYMENT REQUEST
## For the CALENDAR Quarter Ending 06 / 30 / 2025

FC 1646 (12-02-24)
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 |
|---|---|---|---|---|
| | Apr 2025 | May 2025 | Jun 2025 | |
| 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) 630-2872, 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.: 06302025 Medicare B |
| Authorized by: | Date: |

# MEDICARE PART B PREMIUM REIMBURSEMENT INSTRUCTIONS

FC 1646 (02-23-24)

1. **Complete the e-form version of FC 1646 Medicare Part B Reimbursement Quarterly Payment Request** by visiting https://www.valleywater.org/valley-water-retirees-information. If in the process you have any questions, please call the Accounting Unit at (408) 630-2872 for assistance.

2. Please complete one form per Calendar Quarter. Please note that if you make quarterly payments for your Medicare Part B premiums, Valley Water's quarterly reimbursement schedule may differ from your quarterly Medicare payment schedule. The actual reimbursements you receive from Valley Water may be split between quarters.

3. Under Retiree Information, please type 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 Retiree 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 Valley Water to update your address in our system.

5. Under Current Medicare Insurance Part B Reimbursement, 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. Please attach proof of payment or deduction. If you send payments to Medicare Premium Collection Center, please attach a copy of your "Medicare Premium Bill" or copy of Social Security letter.

   To attach proof of payment, click on the "Submit & Sign" button found on the lower right side of the form.

8. Click on "Upload PDF document" > Then "Click Here to Upload" > Select file to upload > "Upload" form > Hit "Continue."

   Click on the "Finalize & Submit" button found on the lower right side of the form to e-sign your form.

9. Under the Signature area, the Retiree must sign and date the form to certify that the information is true and correctly stated. To e-sign your form:

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10. Check the I agree box > Apply Signature; click on the "Finalize & Submit" button found on the lower right side of the form.

    Your e-form will automatically be sent to Christina Madden for approval.

# MEDICARE PART B PREMIUM REIMBURSEMENT QUARTERLY PAYMENT REQUEST

## For the CALENDAR Quarter Ending 09 / 30 / 2025

FC 1646 (12-02-24)
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 |
|---|---|---|---|---|
| | Jul 2025 | Aug 2025 | Sep 2025 | |
| 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) 630-2872, or at: www.valleywater.org. (See side 2 for details.)

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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.: 09302025 Medicare B |
| Authorized by: | Date: |

# MEDICARE PART B PREMIUM REIMBURSEMENT INSTRUCTIONS

FC 1646 (02-23-24)

1. **Complete the e-form version of FC 1646 Medicare Part B Reimbursement Quarterly Payment Request** by visiting https://www.valleywater.org/valley-water-retirees-information. If in the process you have any questions, please call the Accounting Unit at (408) 630-2872 for assistance.

2. Please complete one form per Calendar Quarter. Please note that if you make quarterly payments for your Medicare Part B premiums, Valley Water's quarterly reimbursement schedule may differ from your quarterly Medicare payment schedule. The actual reimbursements you receive from Valley Water may be split between quarters.

3. Under Retiree Information, please type 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 Retiree 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 Valley Water to update your address in our system.

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

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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. Please attach proof of payment or deduction. If you send payments to Medicare Premium Collection Center, please attach a copy of your "Medicare Premium Bill" or copy of Social Security letter.

   To attach proof of payment, click on the "Submit & Sign" button found on the lower right side of the form.

8. Click on "Upload PDF document" > Then "Click Here to Upload" > Select file to upload > "Upload" form > Hit "Continue."

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10. Check the I agree box > Apply Signature; click on the "Finalize & Submit" button found on the lower right side of the form.

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# MEDICARE PART B PREMIUM REIMBURSEMENT QUARTERLY PAYMENT REQUEST

## For the CALENDAR Quarter Ending 12 / 31 / 2025

FC 1646 (12-02-24)


**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.

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**Requested Reimbursement**

| Requester | First Month | Second Month | Third Month | Total Reimbursement Request |
|---|---|---|---|---|
| | Oct 2025 | Nov 2025 | Dec 2025 | |
| Retiree | | | | |
| Retiree's Eligible Spouse/Dependent | | | | |
| **Total Reimbursement for Medicare Part B Premiums** | | | | |

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**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.: 12312025 Medicare B |
| Authorized by: | Date: |

# MEDICARE PART B PREMIUM REIMBURSEMENT INSTRUCTIONS

FC 1646 (02-23-24)

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