California State Teachers' Retirement System
MEDICARE PAYMENT AUTHORIZATION

For CalSTRS use only

CalSTRS does not provide health or dental insurance for retired members.

If you are currently receiving a Social Security benefit and a Medicare premium is deducted from that benefit, please disregard this form. However, if you enroll in Medicare Part A (hospital) and will be charged a premium, you may qualify for the CalSTRS Medicare Premium Payment Program. Furthermore, if you are billed for Medicare Part B (medical), you can use this form to authorize CalSTRS to deduct the monthly premiums from your CalSTRS monthly benefit and send it to Medicare.

This form DOES NOT enroll you in Medicare.

To enroll in Medicare call Social Security at 1-800-772-1213 or TTY 1-800-325-0778.

PLEASE READ THE REVERSE BEFORE COMPLETING THIS AUTHORIZATION

PLEASE COMPLETE				
NAME	(Last)	(First)	(Initial)	SOCIAL SECURITY NUMBER
ADDRESS	(Number)	(Street)	(Apt #)	MEDICARE CLAIM NUMBER
	(City)	(State)	(Zip Code)	TELEPHONE NUMBER ( )

I authorize the California State Teachers' Retirement System to pay Medicare Part A premiums to the federal Centers for Medicare & Medicaid Services (CMS), the Medicare administrator, on my behalf. With my initials and signature below, I request the federal CMS to send premium notices to CalSTRS rather than to me. With this form I also authorize the federal CMS to furnish CalSTRS with such information from time to time as may be necessary to administer this premium payment arrangement.

Initial one or both of the authorizations that apply:

______ I hereby authorize CalSTRS to *pay* **Medicare Part A** (hospital) premiums for me. (See reverse for instructions.)

______ I hereby authorize CalSTRS to *deduct* **Medicare Part B** (medical) premiums, which I must pay, from my monthly benefit and send them to the federal Medicare administrator. (See reverse for instructions.)

I hereby release CalSTRS from liability to me or my estate for any claim arising from the nonpayment of Medicare Part B premiums if designated above, or for premiums paid to the Medicare administrator subsequent to my death.

I understand that if I am electing to have the Medicare Part B premium deducted from my benefit, this deduction will continue until I or Medicare notifies CalSTRS in writing.

RETURN THIS FORM TO CalSTRS ALONG WITH A COPY OF YOUR NOTICE OF MEDICARE PREMIUM PAYMENT (MEDICARE BILL) IN THE ENCLOSED ENVELOPE OR TO THE ADDRESS BELOW

SIGNATURE ✍	DATE (mo/day/yr)

HB-0986 (Rev 02/2004)

Complete and mail to:
CalSTRS Health Benefits, P. O. Box 15275 MS #47, Sacramento, CA 95851-0275
Member Services 1-800- 228-5453 or TTY 916- 229-3541

HOW TO ENROLL IN
CalSTRS MEDICARE PREMIUM PAYMENT PROGRAM

1. Enroll in Medicare. Call Social Security at 1-800-772-1213 or visit your local Social Security office.

   Note: If the Social Security representative tells you that you are not qualified, eligible or do not have enough credits to receive Medicare Part A premium-free, tell the representative that you would like to purchase Medicare Parts A and B. Medicare will then send you a* Notice of Medicare Premium Payment Due for Medicare Parts A and B *(Medicare bill).
2. Your first Notice of Medicare Premium Due (Medicare bill) should arrive the month before your Medicare coverage begins. **Do not pay this bill.**
3. Complete, initial, sign and date this *Medicare Payment Authorization* form after you receive your first Medicare bill.
4. Mail the *Medicare Payment Authorization* form **and** a copy of your Medicare bill to CalSTRS. If you are eligible, CalSTRS will begin paying Medicare Part A premiums or deducting Medicare Part B from your monthly benefit, or both, if you choose.

   Because of normal processing time, you may receive a second premium notice from Medicare's federal administrator (Centers for Medicare and Medicaid Services) stating a past due premium. Do not pay it. Please contact CalSTRS only if you receive a Delinquent Medicare bill.

MEDICARE PAYMENT AUTHORIZATION FORM

To complete this *Medicare Payment Authorization* form

Please use a typewriter or print in black or blue ink. Do not erase; erasures will void your authorization. If you make a mistake, line through the error, make your correction and initial the correction OR obtain a new form. Please make a copy for your records.

Authorization: You must initial one or both statements that apply to you.

- Initial the first statement to have CalSTRS **pay** your Medicare Part A (hospital) monthly premium.
- Initial the second statement to have CalSTRS **deduct** the Medicare Part B (medical) premium from your monthly benefit. We will notify Medicare of the monthly deduction.

Please note

Once CalSTRS begins taking deductions, you or Medicare must notify us in writing of any change in status or to request cancellation of premium deductions.

If you write to us, please include your Social Security number, full name, address, and telephone number including area code. If you call, have your Social Security number ready for the Member Services representative.