VENDOR NO._____

424 Route 8
Maite, Guam 96910
Tel: (671) 475-8900
Fax: (671) 475-8922

GOVERNMENT OF GUAM
RETIREMENT FUND
STABILITY · SECURITY · REWARDS

FY 2025 – MEDICARE PREMIUM REIMBURSEMENT APPLICATION

IMPORTANT NOTICE TO APPLICANT:

1. The Retirement Fund (the "Fund") requires documentation validating:
   a. That you are enrolled in the Medicare medical insurance program **(Copy of Medicare Card)**; and
   b. The commencement date of your Medicare medical insurance coverage; and
   c. ***Your*** monthly premium cost, and payments.

2. In accordance with the Fiscal Year 2025 Budget Law (Public Law 37-125), funds are appropriated from the General Fund to the Retirement Fund to pay the cost of Medicare premiums, inclusive of premiums for Medicare Parts A, B and D, for government of Guam **retirees and their survivors domiciled on Guam**, and who are eligible to receive Social Security income benefits, **and who are eligible to enroll in the government of Guam Group Health Insurance Program**. No government of Guam retiree or their survivor *shall* be required to enroll in the Government of Guam Health Insurance Program in order to receive the reimbursement.

   Bona fide residents of Guam are required to file their tax return in Guam in accordance with the Internal Revenue Service's Publication 570 (relevant page enclosed). As such, the Retirement Fund may require you to provide documentation to confirm that you filed your tax return in Guam.

   If you applied for, and received, reimbursement of Medicare premiums for a period that you did not file your tax return on Guam – **you will be required to repay such reimbursements to the Fund. The Fund may also offset any overpayments, with reimbursements you are entitled to.**

3. **In Fiscal Year 2025,** for those government of Guam retirees and survivors who participate in the Government of Guam Group Health Program and are enrolled in Medicare Parts A and B, **reimbursement shall only be made to those who opt for the Retiree Supplemental Plan (RSP)**.

4. Participants who pay Medicare premiums through automatic deductions from their Social Security or Civil Service retirement annuity, are required to submit to the Fund, a copy of Form SSA–1099 for Calendar Year 2024. **Thereafter, participants shall submit Form SSA-1099 for each calendar year, in which they applied for, and received, a reimbursement of Medicare premiums.**

5. Appropriations are remitted from the General Fund to the Retirement Fund on a monthly basis. ***Reimbursements are contingent on the availability of appropriated funds***, and are processed in the order in which complete and appropriate documentation is received. As such, ***participants are highly encouraged to promptly submit their proof of payment***.

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FY 2025 – MEDICARE PREMIUM REIMBURSEMENT APPLICATION

PLEASE ATTACH A COPY OF YOUR MEDICARE CARD

CHECK ONE: ☐ NEW APPLICANT ☐ CURRENT PARTICIPANT **RETIREMENT PLAN: ☐ DB ☐ DC**

ANNUITANT'S NAME: _____

SOCIAL SECURITY NUMBER: _____

CONTACT INFORMATION: _____
MAILING ADDRESS

_____
CONTACT NUMBER(S)/E-MAIL ADDRESS

HEALTH CARE COVERAGE (CHECK MARK (✓) ALL THAT APPLY):

Medicare		GOVGUAM HEALTH INSURANCE					
		Not	RSP Eligible		RSP	1500 or 2000	
Part A	Part B	Enrolled	Yes	No	Class I, IIa, IIb, III, IVa or IVb	I or II	III or IV

COST OF PREMIUMS:

CALENDAR YEAR	PART A	PART B	PART D
2024	$	$	$
2025	$	$	$

LATEST TAX RETURN FILED: _____ WHERE FILED: ☐ GUAM ☐ OTHER _____
TAX YEAR STATE

I am submitting this application for the purpose of obtaining reimbursement of Medicare premiums in accordance with Public Law 37-125, Chapter XI, Section 1(g). As such, I certify the following:

1. **I am a Government of Guam retiree/survivor <u>domiciled on Guam</u>, and I am eligible to enroll in the Government of Guam Health Insurance Program.**
2. **The premiums, for which I have submitted proof of payment, were not paid by a government organization or entity on my behalf; and**
3. **I am not entitled to, nor have I received, a reimbursement of such payment from any other government organization or entity; and**
4. **I understand, should I enroll in the Government of Guam Group Health Plan, and I am eligible to, but do not, enroll in the Retiree Supplemental Plan (RSP), I am not eligible to receive a reimbursement of my Medicare premium payments. As such, I agree to repay any ineligible reimbursements received accordingly.**

_____
ANNUITANT'S SIGNATURE & DATE

RECEIVED BY GGRF PERSONNEL:

SIGNATURE & DATE: _____

ANNUITANT'S ACKNOWLEDGEMENT RECEIPT OF PAGE 1:

INITIAL & DATE: _____.