J. J. Stanis and Company, Inc.

Rocky Point UFSD Medicare Premium Reimbursement Program

377 Oak Street, Suite 406 Garden City, NY 11530

JUNE 2026 APPLICATION FOR MEDICARE REIMBURSEMENT

In June and December of each year, Rocky Point UFSD reimburses retirees for their Medicare Part B premium. To make sure you and/or your spouse and/or dependent are not receiving a reimbursement from another source, every six months we require Medicare reimbursement recipients to provide the following information. Please fill it out in its entirety.
We require ONE form per household.

Former Employee Name _____
First Middle Last

Street Address _____ City _____ *ST* _____ *ZIP* _____

☐ **Important** – Check here if this is a new address

*For a future paperless option, please provide, *if applicable*

Home or Cell # _____ *E-Mail address _____

Last Four Digits of Social Security # ☐☐☐☐ Date of Birth: ☐☐-☐☐-☐☐☐☐

1) **Are you enrolled in the Empire Plan (NYSHIP)?** ☐YES ☐NO

2) **Are you a Medicare recipient?** ☐YES ☐NO

*If **yes**, do you receive Medicare reimbursement from any other employer?* ☐YES ☐NO

3) **Is your spouse and/or dependent covered under your insurance?** ☐YES ☐NO ☐ N/A
*If **no** or **n/a**, skip to verification section*

*If **yes**, provide spouse's and/or dependent's full name* _____

4) **Is your spouse and/or dependent a Medicare Recipient?** ☐YES ☐NO ☐ N/A

*If **yes**, does your spouse and/or dependent receive Medicare reimbursement from any other employer?* ☐YES ☐NO ☐ N/A

Only ONE employer can reimburse for Medicare

Medicare Part B Premium Reimbursement Verification

ALL MEDICARE RECIPIENTS (including your spouse and/or dependent, if applicable) MUST PROVIDE THE FOLLOWING:

1) Copy of the **SSA-1099 for fiscal year 2025.** You will receive this notice in January 2026.

2) Copy of **"Your New Benefit Amount" verification letter for 2026.** You received this notice from Social Security in November 2025.

If you need to request replacement copies of either of these two documents, please call Social Security Administration (SSA): 1-800-772-1213 or www.ssa.gov/myaccount

If you are not on Social Security at this time, you must send in the *CMS-500 bill(s)* and the proof of payment(s) for each month. Please visit www.medicare.gov/account

Applicant's Signature: _____ **Date:** _____

Spouse and/or Dependent's Signature*: _____ **Date:** _____

*Required if Answers to Questions 3 & 4 are YES and does NOT receive reimbursement from another employer.

HOW TO SUBMIT by 4/30/2026: Please return to **J. J. Stanis and Company, Inc.** by **ONE** of the following methods:

Mail: J. J. Stanis and Company, Inc.
Attn: Rocky Point UFSD Medicare
377 Oak Street, Suite 406
Garden City, NY 11530

OR

Email: Medicare@jjstanisco.com

Fax: (516) 706-7890

If you have any questions, please contact customer service at 516-465-3900.

Note: Presentation of false proof in support of claim on a policy of insurance is prohibited by section of 1202 of the Penal Law.