IBM

Special Health Assistance Provision (SHAP) Reimbursement Request Form

Use this form to submit reimbursement requests for the Special Health Assistance Provision of the IBM Medical Plan. Parts I–V are to be completed by the employee, retiree, or eligible surviving spouse.

Note: Please see the reverse side of the form for eligibility requirements and submission instructions.

Send completed forms to: Acclaris Reimbursement Center PO Box 25171 Lehigh Valley, PA 18002-5171 or Fax to: 1-813-830-7900	**Reimbursement services provided by Acclaris** Please contact us toll free at: 1-888-880-2775 TTY : 1-877-314-2240 Online www.acclarisonline.com **Direct Deposit Available (See Back)**

Part I: General Information (Please Print)

Employee/Retiree/Survivor (Last/First/MI)	Date of Birth	Social Security Number	If claiming SHAP due to disability, please provide your Medicare Part B effective date:
Spouse/Domestic Partner Name (Last/First/MI)	Date of Birth	Social Security Number	If claiming SHAP due to disability, please provide your Medicare Part B effective date:
Child (Last/First/MI)	Date of Birth	Social Security Number	If claiming SHAP due to disability, please provide your Medicare Part B effective date:
Current Address: (If you have moved recently, please contact the IBM Employee Services Center so that they may update your record. Payments can only **be made** to the address on file at the Acclaris Reimbursement Center.)			
Participant Contact Telephone Number:			

Part II: Other Coverage

Are you receiving reimbursements for Medicare Part B premiums from any other source? ☐ Yes ☐ No

If yes, please attach a copy of the other plan's explanation of benefits statement and indicate below:

- Medicaid (if checked please indicate if benefit is for ☐ Self ☐ Spouse ☐ Other). Date of Coverage:_____ _____ _____
- Another Employer (if checked please provide amount received per month): $_____
- Other (if checked please provide amount received per month): $_____

Have you received reimbursement for Medicare Part B premiums for an IBM HRA? ☐ Yes ☐ No

If Yes, please provide the amount received per month

Part III: SHAP Medicare B Premium Reimbursement Request

Please insert the year for each quarter for which you are requesting reimbursement.

Date of Retirement:
Month_____Year _____

Relationship	First Quarter Please List Year	Second Quarter Please List Year	Third Quarter Please List Year	Fourth Quarter Please List Year
Self	Year_____	Year_____	Year_____	Year_____
Spouse	Year_____	Year_____	Year_____	Year_____
Child	Year_____	Year_____	Year_____	Year_____
Domestic Partner	Year_____	Year_____	Year_____	Year_____

Part IV: I certify that the information above and submitted with this form is accurate.

I authorize the release of any information relating to this claim to IBM, its contract administrators, or their representatives as necessary to determine the validity or amount payable on account of this claim. I agree that IBM's contract administrators may release to IBM or any contract administrator designated by IBM, upon IBM's request, any records and information in its possession in connection with this claim.

A photocopy of this authorization shall be as effective as the original. I understand that if I file or authorize another to file a claim knowing that the claim contains false, deceptive, or misleading information or a deceptive or misleading omission, then I may be subject to dismissal, loss of eligibility under the plans, and criminal prosecution.

Part V: Reimbursement for Overpayment

I hereby agree to notify IBM promptly if I become aware of any overpayment of this claim and to reimburse IBM for any amount by which a claim payment is finally determined to have exceeded the applicable benefit.

Only an employee, retiree or eligible surviving spouse is authorized to sign this form.	**Signature:**	**Date:**

Medicare B Premium Reimbursements through SHAP

Note: If you or an eligible dependent are enrolled in Medicare Parts A and B, you may be eligible for SHAP.

Eligibility:

- **If you retired December 31, 1990 or prior**, you are eligible to apply for 80% reimbursement of any Medicare B premium in excess of that which is included in your pension or Medicare B payment. The annual maximum reimbursement per family, including the amount in the pension or Med B payment, will not exceed $900.
- **If you retired after December 31, 1990,** but before December 31, 1996, you are eligible to apply for 80% reimbursement of your Medicare B premium. The annual maximum reimbursement per family is $900.
- **If you retired after December 31, 1996**, and qualify for Medicare on the basis of age, you and your eligible family members will not be eligible for Medicare B premium assistance through the Special Health Assistance Provision.
- **Disability prior to age 65.** Regardless of retirement date, Medicare B premium assistance applies to employees/ retirees or their eligible family members who are under the age of 65 and are covered under Medicare Parts A and B on the basis of disability. **The benefit ceases upon the 65th birthday of the recipient,** unless the recipient meets one of the above retirement eligibility criteria.
- **Plan changes for Dependents.** In accordance with plan changes that became effective on January 1, 2005, dependents (such as new spouse, or new dependent children acquired by birth, adoption, or marriage) acquired after December 31, 2004, are not eligible for SHAP reimbursement under Medicare Part B Premium assistance.

IBM Couples:

- **If both IBM retirees have a retirement date prior to December 31, 1996,** please submit separate forms. Both IBM retirees are eligible to receive 80% reimbursement of their Medicare Part B premium, not to exceed the annual maximum per employee.
- **If your IBM date of retirement is after December 31, 1996, and you are the spouse of an IBM retiree with a date of retirement prior to December 31, 1996**, you are eligible to receive 80% reimbursement of your Medicare Part B premium as a dependent of the eligible retiree. The annual maximum reimbursement per family is $900.

How to Submit a Claim

The Special Health Assistance Provision (SHAP) of the IBM Medical Plan is administered on a calendar year basis. **All claims must be postmarked by December 31 of the following year**. Please refer to the Summary Plan Description for complete details.

- **Complete Sections I–V on the front of this form.** Send the completed form to the address as shown:

  Acclaris Reimbursement Center
  PO Box 25171
  Lehigh Valley, PA 18002-5171
- **Keep a copy of the form for your records.** This will help you reconcile your request with the Explanation of Benefits (EOB) statement that you will receive from the Acclaris Reimbursement Center.
- **Be sure the form is completed in full, signed, and dated.** Incomplete or improperly completed submissions will be returned for correction and resubmission.
- **If you are submitting requests for multiple years, please use separate forms.** All forms must be postmarked by December 31 of the following year.
- **Reimbursement requests can be submitted quarterly.** Please do not submit request on a monthly basis. No evidence of premium payment is required to submit a request.
- **Direct deposit to your checking or savings account is available.** Call the Acclaris Reimbursement Center. for an application.

For questions related to payments or to request a direct deposit application, please contact the Acclaris Reimbursement Center at 1-888-880-2775.

For questions related to plan details, please contact the IBM Employee Services Center at 1-800-796-9876 (TTY: 1-800-426-6537).

Additional Considerations:

- **If you are eligible for a Health Reimbursement Arrangement (HRA) through OneExchange, and also for assistance with your Medicare Part B premiums from the IBM SHAP, it is recommended that you first submit your Medicare Part B premium expense to SHAP, then submit the remaining premium balance against the HRA.**
- **You may not submit the full Part B premium to both SHAP and your HRA because you are allowed to be reimbursed for the full amount only once. If you submit your Part B premium to your HRA first, you risk losing eligibility to be reimbursed through your SHAP benefit for any amount that your HRA does not pay.**
- **Reimbursements can be made only to the employee, retiree, eligible surviving spouse or eligible surviving dependent. Assignment of benefits is not permitted.**
- **Only Medicare B premiums incurred in a given calendar year can be applied to your maximum benefit for that year.**
- **The annual maximum includes amounts you receive from IBM via SHAP and Medicare Part B pension payments combined.**
- **Neither SHAP reimbursements nor Med B payments are considered taxable income.**