Social Security Administration

Important Information

Date: November 21, 2018
BNC#:

SAMPLE

Your Social Security benefits will increase by 2.8 percent in 2019 because of a rise in the cost of living. The Social Security Act requires some people to pay higher premiums for their Medicare Part B (Medical Insurance) and Part D (Prescription Drug Plan) based on their income. We will increase your premiums because of your income. The information in this letter about your premiums is for one year only.

If you currently do not have Medicare Part B or Part D and enroll in 2019, those premiums will also be increased based on your income.

How Much Social Security Will I Get?

- Your new 2019 monthly benefit amount before deductions is: - $877.60
- Your 2019 monthly deduction for the Medicare Part B premium is: - $189.60
  - $135.50 for the standard Medicare premium, plus
  - $54.10 for the income-related monthly adjustment amount (IRMAA) based on your 2017 income tax return
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January 3, 2019 is: - $688.00

C

See Next Page

Form SSA-4926-SM (1-2019)
(30) U.S. GOVERNMENT PUBLISHING OFFICE : 2019 407-200/60004

Your New Benefit Amount

SAMPLE

BENEFICIARY'S NAME:

Your Social Security benefits will increase by **2.8%** in 2019 because of a rise in the cost of living. You can use this letter as proof of your benefit amount if you need to apply for food, rent, or energy assistance. You can also use it to apply for bank loans or for other business. Keep this letter with your important financial records.

How Much Will I Get And When?

• Your monthly amount (before deductions) is	$1,024.50
• The amount we deduct for Medicare Medical Insurance is (If you did not have Medicare as of November 16, 2018, or if someone else pays your premium, we show $0.00.)	$135.50
• The amount we deduct for your Medicare Prescription Drug Plan is (We will notify you if the amount changes in 2019. If you did not elect withholding as of November 1, 2018, we show $0.00.)	$0.00
• The amount we deduct for voluntary Federal tax withholding is (If you did not elect voluntary tax withholding as of November 16, 2018, we show $0.00.)	$0.00
• After we take any other deductions, you will receive on or about January 16, 2019.	$889.00

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. Or visit ***www.ssa.gov/non-medical/appeal*** to appeal online. We would be happy to review the amounts.

If you receive a paper check and want to switch to an electronic payment, please visit the Department of the Treasury's Go Direct website at ***www.godirect.org*** online.

What If I Have Questions?

- Visit our website at ***www.socialsecurity.gov***
- Call us toll-free at **1-800-772-1213** (TTY **1-800-325-0778**)

CMS–500 (09/11)

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

NOTICE OF MEDICARE PREMIUM PAYMENT DUE

This is not a bill.

This premium payment will be deducted from your bank account.

BILLING NOTICE DATE: _____

YOUR CLAIM NUMBER: [ ]

Use Visa/MasterCard/American Express/Discover or make check/money order payable to "CMS Medicare Insurance." Send payment with the bottom portion of this notice in the enclosed envelope to:

Medicare Premium Collection Center
P.O. Box 790355
St. Louis, MO 63179-0355

SAMPLE

	Hospital Insurance Part A	+ Medical Insurance Part B	+ IRMAA Part D	= Total Amount
Current amount due for Part A and/or Part B	$	$		$
Past due amount for Part A and/or Part B	$	$		$
Current amount due for IRMAA Part D			$	$
Past due amount for IRMAA Part D			$	$

Part A: TERMINATION DATE:	
Part B: TERMINATION DATE:	

TOTAL AMOUNT DUE:	$
PAYMENT DUE BY:	

Last payment received: _____ on _____ .

To ensure timely processing, payments must be received by _____ . Any payments received after this date will be included in your next notice.

SEE OTHER SIDE FOR IMPORTANT INFORMATION

Please tear at dotted line and return bottom portion with payment

[ ] If your name or address has changed or is incorrect, check here and complete the back of this notice.

[ ] If the person is deceased, check here.

CLAIM NUMBER: [ ]
Show claim number on check or money order.

AMOUNT PAID: $ [ ][ ][ ][ ].[ ][ ]

AMOUNT DUE: $_____ DUE BY: _____

VISA/MASTERCARD/AMERICAN EXPRESS/DISCOVER NUMBER:
[ ][ ][ ][ ] - [ ][ ][ ][ ] - [ ][ ][ ][ ] - [ ][ ][ ][ ]
EXP. DATE: [ ][ ] - [ ][ ] - [ ][ ]
SIGNATURE: [ ]

Make check/money order payable to: CMS MEDICARE INSURANCE

DO NOT SEND CASH OR STAMPS.

SEND PAYMENT TO:
MEDICARE PREMIUM COLLECTION CENTER
P.O. BOX 790355
ST. LOUIS, MO 63179-0355