The Commonwealth of Massachusetts
Office of the Comptroller
One Ashburton Place, Room 901
Boston, Massachusetts 02108

MEDICARE TAX REFUND REQUEST FORM

Please complete, sign and submit this form to request a Medicare tax refund from the Office of the Comptroller. Departments must submit one Medicare Tax Refund Request form for every tax year the employee is due a refund. Please keep a copy of this form in the employee's personnel file at your department's payroll office for auditing purposes.

Employee Name:_____ **Employee ID #:** _____
(Print Employee's Name) (Print Employee's ID)

Employee SSN: _____**Department:**_____
(Print Employee's Social Security Number) (Print 3-letter Department code)

Dept Contact Name: _____**Tel #:** _____
(Print Name of Person filling out form and their telephone number)

Email Address of Dept Contact: _____

Medicare Tax Refund Request

Total Amount of Medicare Wages: $_____
(Enter total amount of Employee's Medicare Wages)

Amount of Medicare tax refund (1.45% of wages): $_____
(Calculate 1.45% of Employee's Medicare Wages)

If refund is for the current tax year, check this box and indicate the tax year in the space provided below:

☐ **Current Tax Year** **For Tax Year:** _____

Departments must include a screen print of the employee's Medicare tax year-to-date balance with each current tax year request. The year-to-date tax balance can be found in the HR/CMS Tax Balance panel under tax class FICA Med Hospital Ins/EE (Navigation: Go/Compensate Employees/Maintain Payroll Data/Inquire/Tax Balances).

If refund is for a prior tax year, check this box and indicate the tax year in the space provided below:

☐ **Prior Tax Year** **For Tax Year:** _____

Departments must include completed Forms W-2C and W-3C and copies of prior year W2s with each prior tax year request.

Instructions for filing W-2Cs and W-3Cs can be found in the Comptroller's Fiscal Year Policy memo 2001-12 on the Comptroller's website:

http://www.mass.gov/osc

Reason for Refund:

(Please indicate the reason why the Medicare tax refund is being requested)

Signatures:

The undersigned agree that a Medicare tax refund is owed to the employee for the tax year and amount indicated on this form.

The Employee, under penalties of perjury, certifies that he/she has not and will not claim a refund or credit for the overpaid Medicare taxes on their personal income taxes for the tax year indicated on this form.

Employee Signature: _____ **Date:** _____

The Department Payroll Director, under penalties of perjury, certifies that the employee requesting the refund was hired by a Commonwealth employer prior to April 1, 1986, has had no break in service during their employment with the Commonwealth, and therefore is exempt from Medicare tax withholding for the tax year indicated on this form.

Department
Payroll Director Signature: _____ **Date:** _____

Please submit completed form and required documentation to:

Office of the Comptroller
Payroll Unit
1 Ashburton Place, 9th floor
Boston, MA 02108
ATT: Silas Shah

If you have any questions please contact Silas Shah at 617-973-2339 or by email:
Silas.Shah@state.ma.us