
Administered By: Benefit Programs Administration
Telephone (833) 504-3967 (213) 406-2380 Facsimile (562) 463-5894

# BENEFIT CLAIM FORM

Plan Participant Name: _____

Spouse's Name: _____

Address: _____

_____

Date of Retirement or Termination of Employment: _____

Date of Birth: _____ Social Security Number: _____

Daytime Phone #: _____ E-mail Address: _____

1) Reimbursement Limited to Premium Paid. As a Beneficiary in the Medical Expense Reimbursement Plan (Plan) of the Southern California Public Safety Trust (Trust), I understand that I am entitled to a monthly reimbursement benefit for insurance premiums and/or medical expense payments that I make. I understand that the actual Benefit Amount paid by the Trust cannot exceed the actual premiums and medical expenses paid by the Beneficiary. I have elected to receive reimbursement of health (medical, dental, prescription drug, vision) insurance premiums, as stated on page two.

2) Change in Premiums. I understand that, based on the information I provide herein, the Trust will make payments directly to me to reimburse me for my premium payments. I agree to notify the Trust within 30 days of termination or reduction of any of the claimed insurance premiums. If I fail to do so, I will be obligated to reimburse the Trust for any overpayments to me, as well as to pay the Trust for penalties and interest.

3) Monthly Documentation of Premiums. I understand that premium reimbursement will not commence until I have signed this Form and returned it to the Trust Office, along with written documentation from the insurance carrier or another third party showing: coverage type; effective date; premium amount; and proof of my payment of the premiums. **I also understand that I must submit this written documentation from a third party for each month of premiums for which I request reimbursement.** The claim form is only submitted annually, unless my premium amount changes mid-year, but documentation of premiums is submitted for each monthly premium prior to reimbursement. I understand that I can submit the documentation monthly or in batches, but it must be submitted before a claim for reimbursement will be paid and it must be submitted prior to the claim deadline of April 30, 2022.

4) Benefit Amount May Be Adjusted. I understand that my personal Benefit Level is determined based upon the Benefit Amount set and reviewed periodically by the Trustees, and that the Trustees may adjust the Benefit Amount, or other provisions of the Plan, from time to time, which may affect my personal Benefit Level.

5) Income Tax Deductions. I understand that these benefit payments are not taxable, and therefore, expenses reimbursed are not allowed as deductions when filing my individual income tax return.

I am enrolled in the following plan(s) with the following premiums (a copy of each premium invoice is attached along with proof of my payment of the premium):

☐ Medical:

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary ☐ Self ☐ Spouse ☐ Child

☐ Dental:

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary ☐ Self ☐ Spouse ☐ Child

☐ Vision:

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary ☐ Self ☐ Spouse ☐ Child

☐ Drug:

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary ☐ Self ☐ Spouse ☐ Child

☐ Other:

Monthly Premium $_____ Effective Date:_____ Insured Beneficiary ☐ Self ☐ Spouse ☐ Child

**Total Monthly Premium Reimbursement Requested $_____**

6) Premium Payment to Insurance Carrier. I understand that I am responsible for all premium payments to the insurance carrier(s) and that the Trust will reimburse me - not the insurance carrier.

7) Claims Limited to Covered Expenses. If I request and receive reimbursement from the Trust for an expense that does not qualify as a Covered Expense under Plan Section 1.10, I understand that the Trust may pursue recoupment of overpaid benefits and penalties for failure to withhold taxes.

8) Fraudulent Claims. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided, e.g. failure to advise the Trust of termination of coverage or change in premium.

9) Suspension of Benefits During Re-employment with City of Alhambra. I affirm that I am not currently employed by the City of Alhambra (including part-time or contract work) and was not employed by the City of Alhambra when the attached expenses were incurred. I affirm that I do not intend to start employment with the City of Alhambra within the next year, and if I do, I will inform the Trust Office prior to my first day of work. If this Form was signed after February 1, 2022, and I was retired on February 1, 2022, I affirm that I was not employed by the City of Alhambra on February 1, 2022.

I certify under penalty of perjury that the information I have given above is true and correct and that I have read this Form.

_____ _____

Eligible Retiree or Surviving Spouse/Child Signature Date