SOUTHERN CALIFORNIA PUBLIC SAFETY RETIREE MEDICAL TRUST

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

MONTHLY PREMIUM REIMBURSEMENT 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 and Medical Expenses Paid. As a Beneficiary in the Medical Expense Reimbursement Plan (Plan) of the Southern California Public Safety Benefit 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 benefits that the Trust pays 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) Pre-tax Premiums Not Reimbursable. I understand that insurance premiums paid pre-tax are not reimbursable by this Plan. (Payment "pre-tax" means that you paid the premium with income that is not taxable to you, e.g., the premium amount was deducted from your spouse's income prior to taxation. For example, your spouse paid a premium through your spouse's cafeteria plan at his/her job, and that amount of your spouse's salary won't be taxable income to you or your spouse.) I am not submitting for reimbursement of any insurance premiums that were paid pre-tax by an employer or deducted from payroll pre-tax. This also applies to insurance premiums paid to a healthcare plan from my pension plan (e.g., 457 or 401k plan), and claimed as nontaxable income on my personal income tax return pursuant to the HELPS Act.[1]

3) 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 any change (e.g., termination, reduction or increase in any of the claimed insurance premiums). If my premium amount changes, I understand that I will need to submit a new claim form and insurance documentation. If I am reimbursed for premiums that I did not pay, I will reimburse the Trust for any overpayments to me, including penalties and interest, and if I do not repay any overpaid benefits, I understand that the Trust has the right to offset future benefit payments in order to recoup these overpayments.

4) Documentation of Premiums. I understand that premium reimbursement will not commence until I have: (1) signed this Form and returned it to the Trust Office; (2) along with written documentation from the insurance carrier or another third-party showing coverage type, effective date, and premium amount; and (3) submitted proof of my payment of the premiums. I understand that at least once a year I will be required to furnish new verification of my insurance premiums and a new claim form. **I also understand that I must submit proof of my payment of each monthly premium for which I request reimbursement.** I understand that I can submit the proof of payment of premiums monthly or in batches, but proof of payment must be submitted before a claim for reimbursement will be paid.

[1] Healthcare Enhancement for Local Public Safety Officers (HELPS) Act. See page 6 of IRS Publication 575.

I am enrolled in the following plan(s) with the following premiums:

☐ 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 $ __________________

5) Income Tax Deductions Prohibited. I understand that these benefit payments are not taxable, and therefore, the premium amount reimbursed is not allowed as a deduction when filing my individual income tax return. I understand that I am responsible for any income tax penalties incurred related to improper deduction of insurance premiums reimbursed pursuant to this claim.

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 Participating Employer. I affirm that I am not currently employed by a Participating Employer (including part-time or contract work) and was not employed by a Participating Employer when the claimed expenses were incurred. I affirm that I do not intend to start employment with a Participating Employer within the next year, and if I do, I will inform the Trust Office prior to my first day of work.

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

______________________________ ______________________
Eligible Retiree or Surviving Spouse/Child Signature Date