MEDICAL EXPENSE REIMBURSEMENT PLAN OF THE SOUTHERN CALIFORNIA PUBLIC SAFETY RETIREE MEDICAL TRUST

Administered by Benefit Programs Administration
1200 Wilshire Blvd 5th Floor, Los Angeles CA 90017
P: (833) 504-3967● F: (562) 463-5894 ●E: scpublicsafety@bpabenefits.com

Medical Expense Reimbursement Claim Form

Retiree/Beneficiary Name: _____ Date of Birth: _____
Street Address: _____ Social Security Number: _____
City/State/Zip: _____ Phone Number: _____
Email address: _____ Cell Phone Number: _____

Instructions to submit claims for reimbursement:

1. ***Each claim for reimbursement must have supporting documentation of health care services or supplies and proof of payment by you in order for the Trust Office to issue a reimbursement payment.*** Examples of proof of payment include receipts from medical providers or cancelled checks for medical/dental/vision expenses.
2. Claims and supporting documentation become the property of the Plan and cannot be returned to you; please make copies as needed before submitting the claim.
3. Please itemize all expenses below. All claims must be for a Covered Expense under the Medical Expense Reimbursement Plan ("Plan"). (For a definition of "Covered Expense," please refer to Plan Section 1.11 of the Plan.) If you are uncertain as to whether an expense is reimbursable, please contact the Trust Office by phone at **(833) 504-3967** or by email to **scpublicsafety@bpabenefits.com** or refer to IRS Publication 502 at https://www.irs.gov/pub/irs-pdf/p502.pdf.
4. All claims must be received by the Trust Office **no later than April 30th** following the plan year in which the eligible Beneficiary made the payment for the Covered Expense. The plan year is February 1 through January 31, and claims are due by the following April 30th.
5. We suggest that you submit medical expenses that are covered by another medical and/or dental plan to those plans first before requesting reimbursement from this Plan. The Trust will pursue recoupment, and other available remedies, for claims submitted in violation of the Plan rules (e.g., for expenses that are paid elsewhere).
6. Reimbursements will be made directly to the Retiree (or other eligible Beneficiary) by direct deposit; reimbursement payments cannot be assigned to the medical service provider. The Trust Office will process claims once a month, and generally issues payment within 30 days after receipt of all required documentation.

YOU MUST SIGN THE CERTIFICATIONS ON THE NEXT PAGE OF THIS FORM TO RECEIVE REIMBURSEMENT BENEFIT PAYMENTS.

Please complete this Section for reimbursement of one-time miscellaneous medical expenses (not insurance premiums). Attach documentation and additional pages if necessary.

Service Date	**Provided *For*** (Circle one or more)	**Service or Supplies Provider**	**Type of Medical Service or Supplies** (circle one or more)	**Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Child		· Dental · Vision · Rx · Other · Deductible	$_____.__	
	Name:_____ Self Spouse Child		· Dental · Vision· · Rx · Other · Deductible	$_____.__	
	Name:_____ Self Spouse Child		· Dental · Vision· · Rx · Other · Deductible	$_____.__	
			TOTAL REQUESTED	$_____.__	

Certifications and Agreements of Beneficiary

a. I certify that the above claim(s) were incurred for services or supplies on behalf of me or my eligible Beneficiaries. These expenses have not been reimbursed, and I will not seek reimbursement, from any other source.
b. If I request and receive reimbursement from the Trust for an expense that does not qualify for reimbursement under this Plan as a Covered Expense under Plan Section 1.11, or that does not have sufficient documentation, I understand that the Trust may pursue recoupment of overpaid benefits or penalties for failure to withhold taxes, including offsetting future benefits.
c. 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 understand that I am responsible for any income tax penalties incurred related to improper deduction on my individual income tax return of medical expenses reimbursed pursuant to this claim
d. **I affirm that I was not employed by the City of Alhambra (City), including part-time, when the attached expenses were incurred.** Failure to report employment with the City may result in penalties from the federal government, and the Trust may pursue reimbursement of those penalties from the Retiree.
e. I understand that the Plan may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided on this Form. I agree to indemnify and reimburse the Trust on demand for overpayment of benefits, and any liabilities or damages incurred, as a result of a fraudulent claim payment.

I certify under penalty of perjury that I have read this Form and all information on this Form is true, accurate and correct, to the best of my knowledge.

_____ _____ _____

Retiree (or Beneficiary) Signature Print Name Date Signed

Additional Contact information if we are not able to reach you: _____

NAME CELL PHONE NUMBER