Mailing Address:
P.O. Box 2487
Stockton, CA 95201

SOUTHERN CALIFORNIA FIREFIGHTERS BENEFIT TRUST

Telephone: (844) 353-7839
Fax: (209) 940-5255

MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

Retiree Name: _____

Street Address: _____

City/State/Zip: _____

SSN Number: _____

Telephone Number: _____

If you are not the Retiree, please complete the information below:

Name: _____

Address: _____

Relationship to Retiree (circle one):

Spouse Child Domestic Partner

Instructions to submit claims for reimbursement:

1. No Assignment of Claims. Only eligible Beneficiaries can receive payment for reimbursement of medical expenses. All payments will be made directly to the eligible Beneficiary who paid the expense. Payment cannot be assigned to the provider.
2. Submit Claim to Other Insurance Before this Plan. Please submit your expenses to all other medical and/or dental plans, in which you are enrolled, before submitting a claim to this Plan. You must submit your claim and receive payment from all primary and secondary insurance carriers prior to making a claim on this Plan, so that you get maximal coverage under your other plans. This Plan is secondary to your other coverage; this Plan pays Covered Expenses not paid by your other plans.
3. Documentation Required to Be Attached. Each claimed expense must have corresponding written documentation, prepared by an independent third party and submitted with this Claim Form, which includes the following information:
    a) Date medical services were provided (date must be prior to date of claim);
    b) Description of medical services;
    c) Proof of your payment of the expense.

    For example, you may provide a statement from your medical provider to show: amount paid, type of medical service, period of treatment or date incurred, date expense was paid, and the address or Tax ID of the medical service provider. Claims are paid monthly.
4. Make Copies for Your Records. Claims and supporting documentation become the property of the Plan and *cannot be returned to you*. If you wish to keep copies, please make copies before you submit the claim.
5. Benefits Limited to Covered Expenses. All expenses must be itemized and qualify as Covered Expenses under the Medical Expense Reimbursement Plan. (For a definition of "Covered Expenses," please refer to Sec. 1.9 of the Medical Expense Reimbursement Plan.)

YOU MUST SIGN THE STATEMENT ON THE BACK OF THIS FORM TO RECEIVE REIMBURSEMENT BENEFITS.

Medical Expense Claim Form
Southern California Firefighters Benefit Trust

Note: This claim form is for reimbursement of individual medical expenses. If your claim is for a recurring monthly premium, you need to use the "Benefit Claim Form for Premium Reimbursement" which you can obtain from the Trust Office or from the website at Firefightertrust.org

Payment Date	**Provided For** (Circle one or more)	**Provider**	**Type of Service** (Circle one)	**Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Child	Name:_____ Address:_____	Medical Dental Vision Co-Pay Deductible Rx Other: _____	$_____.___	
	Name:_____ Self Spouse Child	Name:_____ Address:_____	Medical Dental Vision Co-Pay Deductible Rx Other: _____	$_____.___	
	Name:_____ Self Spouse Child	Name:_____ Address:_____	Medical Dental Vision Co-Pay Deductible Rx Other: _____	$_____.___	
			TOTAL REQUESTED	$_____.___	

Payment Date: When you or your eligible family member paid for the care or service; Claim form must be submitted within 90 days of the end of the calendar year in which you paid the expense; Provided For: Who received service – give name of Beneficiary and circle relationship; Provider: Who provided the care or service; Type of Service: Please circle one or insert description; Amount Requested: Cannot exceed your out-of-pocket expense after insurance payments from primary and secondary insurance carriers.

Beneficiary Certifications. By my signature below, I certify under penalty of perjury that the foregoing information provided with and on this Claim Form is true and correct and that I have read this Claim Form. I understand and agree to the following terms related to payment of my claim:

a) Source and Limits of Benefit Payment. Benefits will be paid first from my monthly pooled benefit level under Plan Section 3.3 and then the remainder of the "Amount Requested" above will be paid from my Employee Account up to the balance in such account. Any medical expenses above my monthly benefit level and my Employee Account balance are my responsibility.

b) Certification of Covered Expense. I certify that the above claimed expense(s) was incurred for Covered Expenses on behalf of myself or my eligible Beneficiaries. The claimed expenses have not been paid by another health plan or written off by the medical provider, and to the extent covered by another health plan, the claim has been first processed for payment by that health plan.

c) Taxes. I agree to indemnify and reimburse the Trust on demand for any liability it may incur for failure to withhold federal, state or local income tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me, i.e., if I request and receive reimbursement from the Trust for an expense that does not qualify as a Covered Expense under Section 1.9 of the Plan.

d) Recoupment of False/Fraudulent Claims. I understand that the Trust may pursue legal and equitable remedies and/or recoupment of overpaid benefits against me for any false, fraudulent or misleading information provided now or in other communications with the Trust Office.

e) Tax Deductibility. I understand that expenses reimbursed through this Plan are not allowed as deductions or credits when filing my individual income tax return.

Type of documentation attached: _____

_____ _____ _____

Retiree or Beneficiary Signature **Relationship to Eligible Retiree** **Date Signed**