



Administered By: Benefit Programs Administration
Telephone (844) 353-7839 (213) 406-2370 Facsimile (562) 463-5894
www.FirefighterTrust.org

MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

Retiree Name: _____

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

Street Address: _____

Name: _____

City/State/Zip: _____

Address: _____

SSN Number: _____

Relationship to Retiree (circle one):		
Spouse	Child	Domestic Partner

Telephone Number: _____

Instructions to submit claims for reimbursement:

- 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.
- 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.
- 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:
 - Date medical services were provided (date must be prior to date of claim);
 - Description of medical services;
 - 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.
- 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.
- 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.

