PO Box 2487
Stockton, CA 95201

Telephone: (844) 353-7839
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MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

BENEFIT CLAIM FORM FOR PREMIUM REIMBURSEMENT

Plan Participant Name: _____

Spouse's Name: _____

Address: _____

_____

Date of Retirement or Termination of Employment: _____

Daytime Phone #: _____ E-mail Address: _____

1) Election of Coverage(s). As a Beneficiary in the Medical Expense Reimbursement Plan (Plan) of the Southern California Firefighters Benefit Trust (Trust), I understand that I am entitled to reimbursement of health insurance premium payments, from my Employee Account or from my monthly benefit level as a Regular Beneficiary. I understand that the benefits paid by the Trust cannot exceed the actual premiums paid by the Beneficiary. I have elected to enroll in group or individual health (medical, dental, prescription drug, vision) coverage, as described on page two.

2) Reimbursement. 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. If my premium payments change or terminate, for any reason, it is my obligation to promptly advise the Trust of same. 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 penalties and interest. I understand that my reimbursements are limited by my Employee Account balance and/or my monthly benefit level, and any premium payments above that amount are my responsibility. I understand that benefits will be paid first from my monthly pooled benefit level under Plan Section 3.3 and then the remainder of the "Monthly Premium," claimed on the back side of this page, will be paid from my Employee Account up to the balance in such account.

Note: This claim form is for reimbursement of recurring monthly premiums for health insurance. If your claim is for an individual medical expense, you need to use the "Medical Expense Reimbursement Claim Form," which you can obtain from the Trust Office by calling (844) 353-7839.

3) Annual Verification. I understand that the premium reimbursement payments will not commence until I have signed this form (on the back side of this page) and returned it to the Trust Office, with written confirmation from the insurance carrier showing coverage type, effective date, and premium amount**. I understand that at least once a year I will be required to furnish verification that these insurance policies remain in effect and the current premium charged, or more often if deemed necessary by the Trust**. I understand that the Trustees may modify this form at any time in furtherance of prudent administration of the Plan.

4) I am enrolled in the following plan(s) (a copy of each policy and premium statement is attached):

☐ Medical: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Dental: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Vision: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Drug: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Other: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

***I understand that if I have both a pooled benefit and an individual account, the Trust Office will first deduct funds for reimbursement from my pooled account & the remaining premium balance will be deducted from my individual account (as permissible) unless otherwise noted.**

(If you would like an amount less than your remaining premium balance deducted from you Individual Account, please request a specific reimbursement amount below.)

REQUESTED MONTHLY INDIVIDUAL ACCOUNT DEDUCTION: $_____

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

6) I understand that reimbursement will be available only for a Covered Expense as defined in Article I, Section 1.9 of the Plan.

7) I agree to notify the Trust within thirty (30) days of termination or reduction in premium of any of the foregoing policies.

8) I agree to notify the Trust if I have reason to believe that any reimbursement I have received was not for a premium or medical expense.

9) I also 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 or premium 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 Article I, Section 1.9 of the Plan.

I certify under penalty of perjury that the information I have given above is true and correct, and that I have read this form. 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 (or failures to communicate) with the Trust Office, e.g. failure to advise the Trust of termination of coverage or change in premium.

_____ _____

Participant's Signature Date

Please do not write below this line; for Administrative use only

Accepted and agreed to by the Southern California Firefighters Benefit Trust Office

By: _____ _____

Date