MEDICAL EXPENSE REIMBURSEMENT PLAN OF THE HEALTH PROFESSIONALS AND ALLIED EMPLOYEES RETIREE MEDICAL TRUST

ADMINISTERED BY
ZENITH AMERICAN SOLUTIONS
140 SYLVAN AVENUE, STE. 303, ENGLEWOOD CLIFFS, NJ 07632
(201) 947-8000 (201) 947-9192 FAX

MEDICAL EXPENSE OR PREMIUM REIMBURSEMENT CLAIM FORM

RETIREE NAME: ____

STREET ADDRESS: ____

CITY / STATE / ZIP: ____

S.S. # ____________________ **TELEPHONE #** ______________________

IF YOU ARE NOT THE RETIREE, COMPLETE THE FOLLOWING:

NAME AND RELATIONSHIP TO RETIREE: ____

ADDRESS: ____

S.S. # _______ - ________ - __________ **TELEPHONE # (   )** __________________

INSTRUCTIONS TO SUBMIT CLAIMS FOR REIMBURSEMENT:

1. The Trust will reimburse you (or other eligible beneficiary) – not the provider. Claims are processed monthly.
2. Please submit your medical expenses that are covered by other medical and/or dental plans to those plans first. This will help you preserve this benefit for amounts not covered by other plans.
3. You must include supporting documentation each time you submit a claim, such as an EOB or a receipt for a co-pay or bills showing amount and nature of expense, period of time covered by the bill or date incurred, and the address or Tax ID of the service provider.
4. Claims and supporting documentation become the property of the Plan and *cannot be returned to you*. If you wish to keep copies, please make them before you submit the claim.
5. All expenses must be itemized and allowable under the Plan. (For a definition of "Covered Expenses," please refer to Section 1.6 of the Plan.)
6. The amount requested cannot exceed your out-of-pocket expense after any insurance payment or other form of reimbursement paid to you.
7. Attach additional pages if necessary.xs

PREMIUM PERIOD COVERED OR DATE OF SERVICE	PERSON WHO INCURRED THE EXPENSE (*Check ONE OR MORE*)	CARRIER OR PROVIDER	TYPE OF SERVICE / COVERAGE (*Check AS MANY AS APPLY*)	AMOUNT REQUESTED	ADMINISTRATOR USE ONLY
	NAME: ____ SELF ☐ SPOUSE ☐ DEPENDENT ☐		MEDICAL ☐ DENTAL ☐ VISION ☐ CO-PAY ☐ DEDUCTIBLE ☐ PREMIUM ☐ PRESCRIPTION ☐ OTHER ☐	$_____.____	
	NAME: ____ SELF ☐ SPOUSE ☐ DEPENDENT ☐		MEDICAL ☐ DENTAL ☐ VISION ☐ CO-PAY ☐ DEDUCTIBLE ☐ PREMIUM ☐ PRESCRIPTION ☐ OTHER ☐	$_____.____	
	NAME: ____ SELF ☐ SPOUSE ☐ DEPENDENT ☐		MEDICAL ☐ DENTAL ☐ VISION ☐ CO-PAY ☐ DEDUCTIBLE ☐ PREMIUM ☐ PRESCRIPTION ☐ OTHER ☐	$_____.____	
	NAME: ____ SELF ☐ SPOUSE ☐ DEPENDENT ☐		MEDICAL ☐ DENTAL ☐ VISION ☐ CO-PAY ☐ DEDUCTIBLE ☐ PREMIUM ☐ PRESCRIPTION ☐ OTHER ☐	$_____.____	
			TOTAL REQUESTED	$_____.____	

YOU MUST SIGN BELOW THE CERTIFICATIONS ON THE NEXT PAGE OF THIS FORM TO RECEIVE REIMBURSEMENT BENEFITS.

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8. **CERTIFICATIONS; I CERTIFY UNDER PENALTY OF PERJURTY AS FOLLOWS:**
   a. At the time I (or my eligible dependent) incurred the expenses I am claiming, I was not employed by an employer that contributes to the HPAE Retiree Medical Trust. This means also that I was not employed as a per diem employee. If I return to work, even on a per diem basis, with an employer that contributes to the Trust, I will inform the Trust Office promptly. (The rule disallowing benefits to per diems became effective August 1, 2014, based on changes in federal law.)
   b. The information provided on this form is true, accurate and complete, to the best of my knowledge. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided, or failure to notify the Trust Office if I return to work with an employer that contributes to the Trust.
   c. The above claim(s) submitted to the HPAE Medical Expense Reimbursement Plan was (were) incurred for services or premiums on behalf of me or my eligible dependents.
   d. I am not eligible for reimbursement, and have not been reimbursed, for the expenses I claim under any other source.
   e. I have submitted expenses covered by other medical and/or dental plans to those plans first.
   f. If I request and receive reimbursement from the Trust for an expense that does not qualify as a Covered Expense under Section 1.6 of the Plan, I understand that the Trust may pursue legal and equitable remedies and/or recoupment of overpaid benefits against me.
   g. I understand that expenses reimbursed through the Plan are not allowed as deductions or credits when filing my individual income tax return.

TYPE OF DOCUMENTATION ATTACHED: _____

SPOUSE SURVIVING SPOUSE CHILD DOMESTIC PARTNER

_____ _____ _____
RETIREE OR BENEFICIARY SIGNATURE | RELATIONSHIP TO RETIREE – CIRCLE ONE | DATE SIGNED

PLEASE DO NOT WRITE BELOW THIS LINE; FOR ADMINISTRATION USE ONLY

NOTES:

CHECK #_____ ISSUED ON (DATE) _____ FOR THE AMOUNT OF $ _____

CLAIM ADJUDICATED BY (INITIALS) _____ CLAIMS AUDITED AND PAID BY (INITIALS) _____