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. Reimbursements will be made directly to the retiree (or other eligible Beneficiary); reimbursement payments cannot be assigned to the medical service provider. Claims are processed monthly. You must submit your claims no later than January 30th of the year following the date on which the eligible Beneficiary made the payment for the Covered Expense.
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. ***Each claim for reimbursement must have supporting documentation of health care services, supplies or premiums and proof of payment by you in order for the Trust Office to issue a reimbursement payment.*** Examples of proof of payment include: Pension statements of health care premiums deducted from your pension payment; receipts from medical providers or insurance carriers; or cancelled checks or credit card statement showing medical/dental/vision expenses or premiums.
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 Plan Section 1.8.)
6. The amount reimbursed cannot exceed your Benefit Level from the Plan or your out-of-pocket expense after any insurance payment or other form of reimbursement paid to you.
7. Attach documentation, and additional pages if necessary.

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 and Agreements of Beneficiary
   a. I certify that the above claim(s) were incurred for services or premiums 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, 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 I am responsible for all premium payments to the insurance carrier(s) and that the Trust will reimburse me - not the insurance carrier.
   d. I understand that I must submit proof of payment of each insurance premium prior to receiving reimbursement of that premium.
   e. I understand that these benefit payments are not taxable, and thus, reimbursed expenses and premiums are not allowed as deductions when filing my individual income tax return. I understand that insurance premiums paid pre-tax are not reimbursable by this Plan. Payment "pre-tax" means that you paid the premium with income that is not taxable to you, e.g., an employer deducted the premium amount from your spouse's pay prior to taxation. I am not submitting a claim for premiums paid pre-tax. 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 or premiums reimbursed pursuant to this claim.
   f. I affirm that I am not currently employed by an employer that contributes to the HPAE Retiree Medical Trust (including per-diem employment) and was not employed by a contributing employer when the attached expenses were incurred. I affirm that I do not intend to start employment with a contributing employer within the next year, and if I do return to employment with a contributing employer (even as a per diem employee), I will inform the Trust Office prior to my first day of work. Failure to report employment with a contributing employer may result in penalties from the federal government, and the Trust may pursue reimbursement of those penalties from me.
   g. 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 and understood all statements on this Claim Form, and all information on this Claim Form is true, accurate and correct, to the best of my knowledge.

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) _____