CENTRAL VALLEY RETIREE MEDICAL TRUST
MEDICAL EXPENSE REIMBURSEMENT PLAN

Administered by Benefit Programs Administration
1200 Wilshire Blvd. Fifth Floor, Los Angeles CA 90017-1906
P: (213) 406-2347● F: (562) 463-5894 ●E: centralvalley@bpabenefits.com

Medical Expense or Premium Reimbursement Claim Form

Retiree/Beneficiary Name: _____ Date of Birth: _____

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Phone Number: _____

Email address: _____ Cell Phone Number: _____

Instructions to submit claims for reimbursement:

1. ***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 for medical/dental/vision expenses or premiums.
2. Claims and supporting documentation become the property of the Plan and cannot be returned to you; please make copies as needed before submitting the claim.
3. Please itemize all expenses below. All claims must be for a Covered Expense under the Medical Expense Reimbursement Plan ("Plan"). (For a definition of "Covered Expense," please refer to Plan Section 1.8 of the Plan.) If you are uncertain as to whether an expense is reimbursable, please contact the Trust Office by phone at **(213) 406-2347** or by email to **centralvalley@bpabenefits.com** or refer to IRS Publication 502 at https://www.irs.gov/pub/irs-pdf/p502.pdf.
4. All claims must be received by the Trust Office **no later than January 30th** of the year following the date on which the eligible Beneficiary made the payment for the Covered Expense, unless you are submitting a claim for payment from an Individual Account, which has no claims deadline.
5. We suggest that you submit medical expenses that are covered by another medical and/or dental plan to those plans first before requesting reimbursement from this Plan. The Trust will pursue recoupment, and other available remedies, for claims submitted in violation of the Plan rules (e.g., for expenses that are paid elsewhere).
6. Reimbursements will be made directly to the retiree (or other eligible Beneficiary) by direct deposit; reimbursement payments cannot be assigned to the medical service provider. The Trust Office will process claims once a month, and generally issues payment within 30 days after receipt of all required documentation.

YOU MUST SIGN THE CERTIFICATIONS ON THE NEXT PAGE OF THIS FORM TO RECEIVE REIMBURSEMENT BENEFIT PAYMENTS.

Please complete this Section for reimbursement of one-time expenses. Attach documentation and additional pages if necessary.

Service Date	**Provided *For*** (Circle one or more)	**Provider/Carrier**	**Type of Coverage/Service** (circle one or more)	**Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Child		· Medical · Dental · Vision· · Premium · Co-Pay · Other · Deductible · Rx	$_____.__	
	Name:_____ Self Spouse Child		· Medical · Dental · Vision· · Premium · Co-Pay · Other · Deductible · Rx	$_____.__	
	Name:_____ Self Spouse Child		· Medical · Dental · Vision· · Premium · Co-Pay · Other · Deductible · Rx	$_____.__	
			TOTAL REQUESTED	$_____.__	

Please complete the following Section if you are requesting a recurring claim payment for insurance premiums. If at any time your recurring premium amount changes – up or down – or you wish to terminate this recurring payment, you must notify the Trust Office by email to centralvalley@bpabenefits.com.

Type of Premium	**Provided *For*** (Circle one or more)	**Carrier**	**Premium Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Child		$_____.__	
	Name:_____ Self Spouse Child		$_____.__	
	Name:_____ Self Spouse Child		$_____.__	

PLEASE NOTE: Your recurring claim request will automatically terminate on December 31 of each year. If you wish to continue your recurring monthly reimbursement payments, you must submit a new claim form (with new supporting documentation of current year premium amounts) each year by April 1 in order to avoid suspension of your recurring reimbursement payment.

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. I agree to notify the Trust within 30 days of termination or reduction of any of the claimed insurance premiums. 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 for penalties and interest.

c. If I request and receive reimbursement from the Trust for an expense that does not qualify as a Covered Expense under Plan Section 1.8, I understand that the Trust may pursue recoupment of overpaid benefits.

d. 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.

e. I understand that at least annually I will be required to furnish new verification of my insurance premiums and proof of payment.

f. I understand that these benefit payments are not taxable, and therefore, expenses reimbursed are not allowed as deductions when filing my individual income tax return.

g. **I affirm that I am not currently employed (including part-time or contract work) by any Trust participating employer and was not employed by a participating employer when the attached expenses were incurred**. **I affirm that I do not intend to start employment with a participating employer within the next year, and if I do, I will inform the Trust Office prior to my first day of work. If this Form was signed after January 1, 2021, and I was retired on January 1, 2021, I affirm that I was not employed by a participating employer on January 1, 2021**. Failure to report employment with a participating employer may result in penalties from the federal government, and the Trust may pursue reimbursement of those penalties from the Retiree.

h. I certify under penalty of perjury that the foregoing information is true and correct, to the best of my knowledge, and that I have read this Form.

_____ _____ _____

Retiree (or Beneficiary) Signature | Print Name | Date Signed

Additional Contact information if we are not able to reach you: _____

NAME CELL PHONE NUMBER