IAFF MERP
MEDICAL EXPENSE REIMBURSEMENT PLAN

Administered by: Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
Phone: (844) 353-7839
Email:IAFFMERP@bpabenefits.com
Website: https://iaffmerp.org/

CLAIM FORM FOR EXPENSE OR PREMIUM REIMBURSEMENT

Instructions to submit claims for reimbursement:

1. Each claim for reimbursement must have supporting itemized documentation of health care services, supplies and/ or premiums and **proof of payment by you or a qualified beneficiary** in order for the Trust Office to issue a reimbursement payment. Examples of sufficient proof of payment include but are not limited to: PERS statements showing deduction of premiums, itemized invoices with accompanying proof of payment (i.e., bank statement, voided checks, etc.), statements from your provider (enrollment summaries are not accepted); detailed receipts from medical providers or insurance carriers, Medicare statements, or copies of cancelled checks for medical/dental/vision premiums**. All submitted out-of-pocket expenses related to items purchased or services rendered must include detailed information to allow for processing in addition to applicable proof of payment.** (However, see item #2 below regarding an exception.)
2. **If you are submitting a claim for reimbursement of your share of medical care costs, as shown on an Explanation of Benefits (EOB), you do not have to submit proof of your payment of the expense, as long as you check the box above your signature certifying that you have paid the amount shown on the EOB as your share of the costs.**
3. Medical expenses covered by other medical, vision, and/or dental insurance plans must be submitted 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).
4. 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.
5. 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 1.11.) If you are uncertain as to whether an expense is reimbursable, please contact the Trust Office by phone at (844) 353-7839 or IAFFMERP@bpabenefits.com or refer to IRS Publication 502 at https://www.irs.gov/pub/irs-pdf/p502.pdf.
6. You must submit your written claims no later than March 31st of the year following the date on which the eligible Beneficiary made the payment for the Covered Expense.
7. All claim submissions received and fully substantiated with supporting documentation on or before the 5th of the month will be reimbursed on the 25th of the month.
8. 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 or service carrier. The Trust Office will process claims once a month and generally issues payment within 30 days after receipt of all required documentation.
9. One-time claim expenses submitted are required to be accompanied by a signed and completed claim form with **each** submission.
10. All claim forms must include completed demographic information, premium and claim information being submitted, completed Summary of Request, a live signature made by the member/ collecting Beneficiary, and date. Claim Forms may not be reused for multiple submissions made on different dates.
11. Expenses covered by HSA/FSA/HRA plans, tax credits, or any additional outside sources are not considered reimbursable via the IAFF MERP trust. For more information on MERP regulations, please see the Summary Plan Description provided on https://iaffmerp.org/.

Pretax Premiums Notice:

Taxation of Certain Premium Reimbursements from this Plan. Generally, your reimbursement benefits from this Plan are not taxable income to you. However, there are a couple exceptions to that rule (see below), and you can request a taxable benefit payment on this Claim Form for these circumstances by initialing and filling in the taxable benefit amounts requested below.

a) *Premiums paid with pre-tax income*. Payment with "pre-tax" income means that I paid the premium with income that is not taxable to me, *e.g.,* the premium amount was deducted from my spouse's income prior to taxation.

b) *Income tax deductions prohibited*. If you deduct your health insurance premium on your personal income tax return, then you cannot get reimbursement of those premiums from this Plan tax-free. If you want reimbursement and anticipate claiming a deduction on your personal income tax, then you can request a taxable benefit payment on this Claim Form.

c) *Taxable benefits and tax penalties*. If you request a taxable benefit payment on this Claim Form by filling out the statement, you will receive an IRS Form 1099 for those benefit payments from the Trust. You are responsible for any income tax on this taxable income and any penalties incurred related to improper deduction on your individual income tax return of medical expenses or premiums reimbursed by this Plan.

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Did you know you can access your personalized member portal? You can register today! Please navigate to the IAFF MERP Member Portal at https://iaffmerp.org. Your claim will be processed quicker with our streamlined online system. You will receive important updates and notifications directly through the portal.

Retiree/Beneficiary Name: _____ Date of Birth: _____

Spouse's Name: _____ Date of Birth: _____

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Phone Number: _____

Email address: _____ Cell Phone Number: _____

SUMMARY OF REMIBURSEMENT REQUEST

Total Out-of-pocket Premiums: $_____

Total Out-of-pocket Pre-tax Premiums: $_____

Total Out-of-pocket Claims: $_____

Total Payment Requested: $_____

Individual Account Balance Authorization:

If your total requested reimbursement claim exceeds your Monthly Benefit Level, the Trust Office will automatically pay the excess claimed amount from your Individual Account balance, if any. Please indicate using the provided options to allow or restrict the use of any applicable Individual Account funds. Forms submitted without a selection will have the default applied allowing reimbursement

☐ **Yes** – I authorize the use of available Individual Account funds ☐ **No** – Do not issue from my Individual Account

Explanation of Benefits (EOB):

☐ I am submitting an Explanation of Benefits (EOB) from my health insurance carrier or plan and requesting reimbursement of my share of medical costs as indicated on the EOB. By checking this box, I certify that I have paid the amount indicated as my share of costs, that this claimed amount has not been reimbursed by insurance or otherwise, and that I will not seek reimbursement of this claim amount from any other plan covering health costs.

CLAIMS REIMBURSMENT DETAILS

Service Date/Premium Period	Date Paid	Patient Name	Provider/Carrier	Type of Coverage/Service	Amount Requested
				☐ Medical ☐ Dental ☐ Vision ☐ Co-Pay ☐ Rx ☐ Pre-Tax Premium ☐ Post-Tax Premium ☐ Other:_____	$_____

Service Date/Premium Period	Date Paid	Patient Name	Provider/Carrier	Type of Coverage/Service	Amount Requested
				☐ Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐ Pre-Tax Premium ☐Post-Tax Premium ☐ Other:_______________________	$________
				☐ Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐ Pre-Tax Premium ☐Post-Tax Premium ☐ Other:_______________________	$________
				☐ Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐ Pre-Tax Premium ☐Post-Tax Premium ☐ Other:_______________________	$________
				☐ Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐ Pre-Tax Premium ☐Post-Tax Premium ☐ Other:_______________________	$________
				☐ Medical ☐Dental ☐Vision ☐ Co-Pay ☐ Rx ☐ Pre-Tax Premium ☐Post-Tax Premium ☐ Other:_______________________	$_______

Certifications and Agreements of Beneficiary

a) I certify that the above claim(s) were incurred for services and/or premiums on behalf of me or my eligible Beneficiaries. These expenses have not been reimbursed, and I will not seek reimbursements 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 the benefits paid to me by the Trust cannot exceed the actual premiums and/or medical expenses paid by eligible Beneficiaries.

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 I must submit proof of payment of each insurance premium prior to receiving reimbursement of the premium.

f) **I understand that at least annually I will be required to furnish a new Claim Form and new third-party documentation of my insurance coverage and proof of payment of premiums**. 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.

g) 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 the Plan cannot reimburse, on a tax-free basis, insurance premiums that are paid with pre-tax income and that I must request a taxable benefit payment on page 2 of this Claim Form for reimbursement of premiums paid with pre-tax income. I understand that the amount requested as a taxable benefit payment on page 1 will be taxable income to me, and 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.

h) I affirm that I am not currently employed by any Trust Participating Employer (including part-time or contract work) 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 return to work, I will inform the Trust Office prior to my first day of work. I acknowledge that this Plan is a retiree-only plan, and therefore, a Beneficiary cannot receive benefits while employed by a Participating Employer. I understand the Trust could be subject to penalties under federal law, if benefits are paid during employment, and the Trust may seek to recover those penalties from me.

i) I understand that the Plan may pursue legal and equitable remedies against me for any false, fraudulent, or misleading information provided on this Claim 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 3 pages of this Claim Form, and all information on this Form is true, accurate and correct, to the best of my knowledge.

______________________________ ______________________________ ______________________________

Eligible Retiree (or Beneficiary) Signature | Print Name and Relationship to Retiree | Date Signed