IAFF MERP
MEDICAL EXPENSE
REIMBURSEMENT PLAN

Medical Expense or Premium Reimbursement Claim Form

Administered by Vimly Benefit Solutions PO Box 6 ● Mukilteo, WA 98275
P: 425-367-0743 ● F: 866-676-1530 ●E: iaff-merp@vimly.com

Retiree/Beneficiary Name: _____ Date of Birth: _____

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Cell Phone Number: _____

Email address: _____ Retirement Date: _____

Medical Expenses: Please complete this Section if you are seeking reimbursement for one-time miscellaneous medical expenses (not insurance premiums).

Attach documentation and additional pages, if necessary.

Service Date	**Provided *For*** (Circle one or more)	**Service or Supplies Provider**	**Type of Medical Service or Supplies** (check one or more)	**Amount Requested**	**Administrator Use Only**
	Name:_____ Self ☐ Spouse ☐ Child ☐		☐Dental ☐ Vision ☐ Premium ☐Other ☐ Deductible ☐ Rx	$_____.__	
	Name:_____ Self ☐ Spouse ☐ Child ☐		☐Dental ☐ Vision ☐ Premium ☐Other ☐ Deductible ☐ Rx	$_____.__	
	Name:_____ Self ☐ Spouse ☐ Child ☐		☐Dental ☐ Vision ☐ Premium ☐Other ☐ Deductible ☐ Rx	$_____.__	
			TOTAL REQUESTED*	$_____.__	

Premiums: Please complete the following Section if you are requesting reimbursement for insurance premiums. You must submit this Claim Form annually along with written documentation from the insurance carrier showing coverage type, effective date, and premium amount. In addition, you must submit monthly proof of your payment of premiums, unless you pay your insurance premium on some other frequency. You can batch your proof of premium payments and submit several months at one time, but you will not receive reimbursement for a monthly premium until the Trust Office receives proof of that month's premium payment. If you are claiming reimbursement of Medicare premiums, you generally only need to provide your Social Security statement annually, showing the Medicare deduction from your Social Security payments, along with this Claim Form; this does not apply to Medicare supplemental premiums or Medicare premiums paid out-of-pocket. Any time your premium amount changes, you must provide a new claim form and new insurance carrier documentation to the Trust Office via email to iaff-merp@vimly.com.

Type of Premium	**Provided *For*** (Circle one or more)	**Insurance Carrier**	**Paid PRE-Tax Amount**	**Paid POST-Tax Amount**
	Name:_____ Self Spouse Child		$_____.__	$_____.__
	Name:_____ Self Spouse Child		$_____.__	$_____.__
	Name:_____ Self Spouse Child		$_____.__	$_____.__

Total Monthly Premium Reimbursement Requested* $_____

I request the following amount as a taxable benefit payment until I submit a new Claim Form $ _____ (See #7 instructions p.3)

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 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 that 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 1 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[1] (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.

_____ _____ _____

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

YOU MUST SIGN THIS CERTIFICATION TO RECEIVE REIMBURSEMENT BENEFIT PAYMENTS.

*If your total requested reimbursement claim for premiums and/or medical expenses exceeds your Monthly Benefit Level, the Trust Office will automatically pay the excess claimed amount from your Individual Account balance, if any. If you **do not** want the Trust Office to pay the excess claimed amount from your Individual Account balance, please communicate that direction by initialing the statement below.

____ By entering my initials, I direct the Trust Office as follows: **Do not** pay my reimbursement claim from my Individual Account balance. I understand that my reimbursement request will be limited to my Monthly Benefit Level and the excess claimed amount will carry over to be paid in a month when I have not submitted claims equal to my Monthly Benefit Level.

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

NAME CELL PHONE NUMBER EMAIL

[1] A list of Participating Employers is available on the IAFF MERP web portal at https://iaff-merp.simon365.com.

Instructions to submit claims for reimbursement:

1. The Trust Office will make reimbursement benefit payments directly to the Eligible Retiree (or other eligible Beneficiary) by direct deposit; reimbursement benefit payments cannot be assigned to the medical service provider or insurance carrier. ***See examples below.***
2. Please submit medical expenses covered by other medical, vision, and/or dental insurance plans 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).
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 showing health care premiums deducted from your pension payment; receipts from medical providers showing date of service, patient and services rendered, proof of premiums payment from insurance carriers; receipts or invoices marked "paid" by the medical provider showing date of service, patient and services rendered; cancelled checks; or bank or credit card statements showing payment to the medical provider or insurance carrier along with information showing date of service, patient and services rendered.
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 expenses must qualify as Covered Expenses under the Medical Expense Reimbursement Plan (the "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 **(425) 367-0743** or by email at **iaff-merp@vimly.com** or refer to IRS Publication 502 for tax deductible medical expenses 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. 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.

Return your completed Claim Form by mail, fax, web portal, or email to the Trust Office:

IAFF MERP Trust Office
c/o Vimly Benefit Solutions
PO Box 6, Mukilteo, WA 98275
P: 425-367-0743 F: 866-676-1530
E: iaff-merp@vimly.com
https://iaff-merp.simon365.com

Your claims must be received by the Trust Office no later than the 25th of the month to receive a reimbursement by the 15th of the following month. If received after the 25th, you will be paid in the next month. Example: Received January 20, reimbursement received February 15th. Received January 27, reimbursement received March 15.

Claims for the calendar year must be postmarked by March 31st of the following year in order to be paid. Example: Claim in October 2023 must be received by March 31, 2024 to be eligible for reimbursement.