



## **IAFF MERP MEDICAL EXPENSE REIMBURSEMENT PLAN**

Administered by Vimly Benefit Solutions

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### **Frequently Asked Questions regarding 2024 Annual Verification**

#### **Q: Do I have to submit a claim form?**

**A:** Yes, you must submit a claim form every year. This proves you are still eligible to receive a benefit and are not working for a contributing employer. This also provides us with your current address.

- a. If you have a claims bank, meaning you have submitted more than your monthly benefit and we are paying you, you still need to submit a new claim form to prove you are still eligible.

#### **Q: Do I have to submit monthly proof of premium payment?**

**A:** Yes. Per the new rules under the IRS code, the Trust is required to get monthly proof of premium payments in order for you to continue to be reimbursed.

#### **Q: Are there any exceptions?**

**A:** One exception is if you are on Medicare. You just need to provide proof of your current deduction. This letter should have been mailed to you in December.

**A:** Another exception is if you have retiree coverage under the IAFF Health & Wellness Trust or another Trust administered by Vimly.

#### **Q: When is the 2024 Annual Verification due?**

**A:** Your 2024 Annual Premium Verification is due January 25<sup>th</sup> in order for your premiums to be reimbursed by February 15<sup>th</sup> claims disbursement. If you do not get your verification documents in by January 25<sup>th</sup>, your claim will be paid based on when you do submit it. In order for a claim to be paid by the 15<sup>th</sup> of each month, it must be submitted by the 25<sup>th</sup> of the prior month.

#### **Q: What happens if I do not submit my annual verification?**

**A:** If you do not submit your annual verification, payments will stop until you submit a new claim form with proof of each month of premiums

**Q: What do I put in the “amount requested”?**

**A:** You can put your monthly benefit amount **OR** your premium amount

**Q: Do I need to fill out the direct deposit form?**

**A:** Only if you have new bank information or wish to change where your funds are deposited.

**Q: Can I now submit Pre-tax premiums?**

**A:** Yes, pre-tax premiums will be accepted effective with 1/1/2024 proof of premiums. You must notate this on the claim form.

**Q: How do I know if it is a pre-tax premium?**

**A:** You will need to look at your paystub under deductions. If it shows pre-tax you must claim this as pre-tax and you will receive a 1099 form in January of the following year to claim as taxable income.

**Q: If I don't receive payment verification until after the 25th, what happens with my MERP reimbursement?**

**A:** Once you submit your proof of premium and submit to the Trust Office it will be reimbursed with the next payment cycle.

**Q: What is the claims deadline?**

**A:** The Trust Office must receive your proof by the 25<sup>th</sup> of the month for payment by the 15<sup>th</sup> of the following month.

**Q: What if my premium amount exceeds my monthly benefit amount?**

**A:** If your premium cost exceeds your monthly benefit, we can continue to pay you until your initial proof is exhausted; at which time you must submit additional proof of payment.

**Example:** if your monthly benefit amount is \$200 and your premium is \$1,000, you would only need to submit your proof of premium every 5<sup>th</sup> month. The Trust Office will pay you the \$200 a month until the \$1000 is paid out.

**Q: Do I need to include everything at the top of page 1 of the claim form?**

Retiree/Beneficiary Name: _____	Date of Birth: _____
Street Address: _____	Social Security Number: _____
City/State/Zip: _____	Cell Phone Number: _____
Email address: _____	Retirement Date: _____

**A:** All information is needed to be filled out at the top of page 1 of the claim form. **NOTE:** We do not need your full SSN, the last four are sufficient

**Q: What is the first box for on the claim form?**  
and additional pages, if necessary.

Service Date	Provided <i>For</i> (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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Premium <input type="checkbox"/> Other <input type="checkbox"/> Deductible <input type="checkbox"/> Rx	\$ _____	
	Name: _____ Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Premium <input type="checkbox"/> Other <input type="checkbox"/> Deductible <input type="checkbox"/> Rx	\$ _____	
	Name: _____ Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Premium <input type="checkbox"/> Other <input type="checkbox"/> Deductible <input type="checkbox"/> Rx	\$ _____	
<b>TOTAL REQUESTED*</b>				\$ _____	

**Premiums:** Please complete the following Section if you are requesting reimbursement for insurance premiums. You must submit this Claim Form annually along

**A:** This box is used for items you are submitting such as co-pays, deductibles, pharmacy receipts, etc. Please include as much information as possible.

**Important:** Receipts must include patient name, date of service, type of service, provider name and payment amount by the participant.

**Q: What is the second box for on the claim form?**

FOR MORE DETAILS GO TO [www.simons.com](https://www.simons.com) OR CALL 1-800-333-3333

Type of Premium	Provided <i>For</i> (Circle one or more)	Insurance Carrier	Paid PRE-Tax Amount	Paid POST-Tax Amount
	Name: _____ Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		\$ _____	\$ _____
	Name: _____ Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		\$ _____	\$ _____
	Name: _____ Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		\$ _____	\$ _____

**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)**

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Dr. 11/30/

**A:** This box is used for premiums such as medical, dental, vision, prescription and eligible long-term care premiums. You will need to note if it is pre-tax or post tax.

**Q: How do I submit my claim form and documentation?**

**A:** You can submit your claim form and documentation via the regular mail, upload through the SIMON® portal, email or fax.

**Q: When is the claims deadline?**

**A:** Claims for dates of service in 2023 must be postmarked by March 31<sup>st</sup>, 2024 in order to be reimbursed.