QUALIFIED BENEFIT REIMBURSEMENT CLAIM FORM

DELRAY BEACH POLICE, FIREFIGHTERS & PARAMEDICS RETIREE BENEFIT FUND INFORMATION

Name (Last, First, MI) _____

Social Security Number _____

Street Address _____

Email Address _____

City, State, Zip Code _____

Phone Number _____

REIMBURSEMENT REQUEST FOR QUALIFIED OUT-OF-POCKET EXPENSES

REMINDER: You must include proof of each expense (e.g. Explanation of Benefits, detailed receipts, etc.) Claims for employee-paid premiums deducted after-tax require a letter from the employer confirming that no pre-tax option exists. Premiums paid by an employer or deducted pre-tax through a section 125 plan are not eligible for reimbursement.

Date of Service	**Service Provider or Item Purchased From** (e.g. Dr. Smith, Hospital, Pharmacy, etc.)	**Description of Service/Item** (e.g. office visit, Hospital Care, Dental, Prescription, etc.)	**Name of Qualified Individual for Whom the Expense is Incurred/Relationship**	**Amount You Paid**
				$
				$
				$
				$
				$

Have more expenses? Include an itemized list on a separate sheet of paper. If you want to note certain items on receipts, circle them. Do not use a highlighter. Keep copies of everything you submit.

Total Reimbursement Request	$

CERTIFICATION (Signature is Required)

I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of the submitted claim to Anchor Benefit Consulting is an accurate statement of my (a) unreimbursed medical/dental/vision expenses after payment by insurance (if any) and/or; (b) medical/dental/vision tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by an employer, and are not eligible for pre-tax deduction through my employer's section 125 cafeteria plan.

Signature: _____ **Date: _____**

Secure File Upload: via http://www.anchorbenefit.com/secure-file-upload.html
For questions, please call customer service at 1-(800)-845-7629 or (407)-667-8766.

Mail to: P.O. Box 945260, Maitland, FL 32794

www.anchorbenefit.com