



Miramar Firefighters' Local 2820 VEBA Trust Fund Request for Reimbursement of Non-Recurring Expenses

Part A: Participant Information

Participant Name (Last Name, First Name, MI)	Address
Social Security Number	City, State Zip
Phone Number	Email Address

Part B: Request to Reimburse Non-Recurring Expenses

Use this section to request a reimbursement of a non-recurring expense (e.g. co-payments, medications, out-of-pocket expenses).

Summary of Qualifying Expenses

Date Expense Incurred*	Taxable/ Non-Tax	Name of Member or Dependent	Relationship To Member	Service Provider	Description of Service	Amount to Reimburse
	<input type="checkbox"/> Taxable <input type="checkbox"/> Non-Tax					
	<input type="checkbox"/> Taxable <input type="checkbox"/> Non-Tax					
	<input type="checkbox"/> Taxable <input type="checkbox"/> Non-Tax					
	<input type="checkbox"/> Taxable <input type="checkbox"/> Non-Tax					
	<input type="checkbox"/> Taxable <input type="checkbox"/> Non-Tax					
					TOTAL REIMBURSEMENT:	\$

*Incurred date is the date of service, not the billing or the payment date.

The administrator processes all reimbursement claims quarterly. Eligible claims received by the 10th of March, June, September, and December will process on the 1st business day of the **NEXT** month.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

I hereby certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits through the Miramar Firefighters' Local 2820 VEBA Trust Fund.

I further certify the following:

- The qualifying expenses have not been reimbursed and are not reimbursable under any other plan or by Medicare.
- I understand that I cannot deduct any reimbursed expenses on federal or local income tax returns.
- I am responsible for requesting cessation of automatic reimbursement of recurring expenses when I no longer incur those expenses, and I will retain sufficient documentation for all such expense. The VEBA Trust Fund reserves the right to periodically request additional documentation for recurring expenses.

I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement claim. I understand that I will be liable for payment of all related taxes, including any Federal, state or local income tax on amounts paid from the VEBA Trust Fund for non-qualifying and non-taxable expenses.

Participant Signature

Date



IAFF Local 2820
Miramar, FL

Miramar Firefighters' Local 2820 VEBA Trust Fund

Request for Reimbursement of Recurring Expenses

Important: Use this form to request automated reimbursement of recurring expenses (e.g. insurance premiums).
Note: Payment **must** be made to the account holder. Payment will **not** be made directly to any insurance company or third party.

Part A: Participant Information

Participant Name (Last Name, First Name, MI)	Address
Social Security Number	City, State Zip
Phone Number	Email Address

Part B: Request to Reimburse Recurring Expenses

You are responsible for ensuring that you receive automatic reimbursements only for qualifying medical expenses. You are also responsible to make certain that you stop automatic reimbursements if you no longer incur those expenses. You must provide documentation of the recurring expense with the request, and you must retain sufficient documentation for all recurring expenses. Supporting documentation must show that premiums are paid after taxes and include the following: (I) Insurer Name; (II) Type of Insurance; (III) Policyholder Name; (IV) Recurring Expense Amount; and (V) Coverage Period.

Summary of Qualifying Expenses

1. **BEGIN** recurring Reimbursement: Taxable Non-Taxable
 Begin Date: _____ Amount: \$ _____ End Date: _____

2. **CHANGE** recurring Reimbursement: Taxable Non-Taxable
 Old Amount: _____ New Amount: \$ _____ Effective Date: _____

3. **END** recurring Reimbursement: Taxable Non-Taxable
 Amount: \$ _____ Last Payment Date: _____

The administrator processes all reimbursement claims quarterly. Eligible claims received by the 10th of March, June, September, and December will process on the 1st business day of the **NEXT** month. Quarterly reimbursement payments will continue until your account is depleted, unless an end date is provided.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

I hereby certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant while the undersigned was eligible to receive benefits through the Miramar Firefighters' Local 2820 VEBA Trust Fund.

I further certify the following:

- The qualifying expenses have not been reimbursed and are not reimbursable under any other plan.
- I understand that I cannot deduct any reimbursed expenses on federal or local income tax returns.
- I am responsible for requesting cessation of automatic reimbursement of recurring expenses when I no longer incur those expenses, and I will retain sufficient documentation for all such expense. The VEBA Trust Fund reserves the right to periodically request additional documentation for recurring expenses.

I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. I understand that I will be liable for payment of all related taxes, including any Federal, state or local income tax on amounts paid from the VEBA Trust Fund for non-qualifying and non-taxable expenses.

Participant Signature

Date



IAFF Local 2820
Miramar, FL

Miramar Firefighters' Local 2820 VEBA Trust Fund

Required Documentation for Claims

NON-TAXABLE REIMBURSEMENTS

Health Insurance and Long-Term Care Premium Benefits. Written proof that premiums are payable or were paid by the member. Submit written direction to pay the benefit directly as a full or partial payment to the provider of such insurance.

Reimbursement of Uninsured Medical Expenses. Copy of statement from medical provider.

Burial Benefit. Invoice or paid receipt from a funeral home, cemetery, burial society or monument company.

Child Care Expenses. Invoice or paid receipt from the childcare provider.

Summer Camp Benefits for Members' Dependents. Summer camp expenses for preschool and school-age dependents, proof of payment required.

TAXABLE REIMBURSEMENTS

Sick and Vacation Pay Benefit (Benefit to be paid to Employer, which shall disburse the benefit to member as part of the member's regular paycheck). Documentation from Employer needed for the time period benefit is to cover.

Vacation Expenses. Invoice or paid receipt from a common carrier (air, train, bus or cruise line), lodging establishment, auto rental company, restaurant, travel agent, attraction or similar vendor.

Housing Assistance. Invoices, closing statements, or paid receipts for the purchase, rental, or renovation of member's primary residence to include down payments, closing costs, bank or mortgage company fees, mortgage interest buy downs and initial rent costs (such as security and utility deposits and first and last months' rent).

Disaster Relief. Invoice or paid receipt for temporary living expenses.

Education beyond high school level or Training Benefits. Invoice or paid receipt from an accredited institution of higher learning or licensed vocational school. Invoice or paid receipt and *attest that the educational expense is not also paid or reimbursed by member's employer, scholarship, veteran's benefits, or any third party (please request form for this)* for tuition, books and fees incurred by member for education or training courses taken at any accredited or licensed institution or post-secondary or vocational education. BENEFIT FOR MEMBERS ONLY

Term Life Insurance. Invoice or paid receipt for premiums on member's life.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.