



SARASOTA FIREFIGHTERS INSURANCE TRUST FUND

Request for Reimbursement of **Non-Recurring** Expenses

Martin A. Ferris, Founding Chairman

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 Medical Expenses

Date Expense Incurred*	Name of Member or Dependent	Relationship	Service Provider	Description of Service	Amount to Reimburse
*Incurred date is the date of service, not the billing or the payment date.				TOTAL REIMBURSEMENT:	\$

Eligible claims received by the 15th calendar day of the month will be processed on the 1st business day of the **NEXT** month. All eligible claims received after such date shall be processed on the 1st business day of the 2nd month from the date when it was received.

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 and paid by the Participant, the Participant's spouse, or the Participant's eligible dependents while the undersigned was eligible to receive benefits through the Sarasota Firefighters Insurance Trust Fund.

I further certify the following:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- I understand that I cannot deduct any reimbursed expenses on my 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 expenses. The Sarasota Firefighters Insurance Trust Fund reserves the right to periodically request additional documentation for recurring expenses to ensure compliance and that my reimbursements may be suspended until such time as necessary requested documentation is received.

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 Sarasota Firefighters Insurance Trust Fund for non-qualifying medical expenses.

Participant Signature
Date