West Palm Beach PBA Retiree Health Benefit 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 Medical Expenses

1. ☐ **BEGIN** recurring Reimbursement:

Begin Date: _____ Amount: $_____ End Date: _____

2. ☐ **CHANGE** recurring Reimbursement:

Old Amount: _____ New Amount: $_____ Effective Date: _____

3. ☐ **END** recurring Reimbursement:

Amount: $_____ Last Payment Date: _____

The administrator processes all reimbursement claims monthly. Eligible claims received by the 10th day of each month will process on the 1st business day of the **NEXT** month. Monthly 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 West Palm Beach PBA Retiree Health Benefit Fund.

I further certify the following:

- The medical 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 Benefit 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 West Palm Beach PBA Retiree Health Benefit Fund for non-qualifying medical expenses.

Participant Signature

Date

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

West Palm Beach PBA Retiree Health Benefit 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 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:**	**$**

The administrator processes all reimbursement claims monthly. Eligible claims received by the 10th day of each month 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 West Palm Beach PBA Retiree Health Benefit 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 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 Benefit 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 West Palm Beach PBA Retiree Health Benefit Fund for non-qualifying medical expenses.

Participant Signature

Date

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.