**SDCERA Health Insurance Allowance and Medicare Part B Premium Reimbursement Plan**

**Claim Form**

**Complete this claim form in its entirety, provide legible documentation as instructed, and sign below. Please print clearly.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Your Name (Last, First, MI)** | **Social Security Number** | | **Your Employer Name** | | |
|  |  | | **San Diego County Employees**  **Retirement Association** | | |
| **Address** | | **City** | | **State** | **Zip Code** |
|  | |  | |  |  |

**Insurance Premium Claims (other than Medicare)**

Please include appropriate documentation as required by IRS regulations and the SDCERA plan with this completed claim form as follows:

* Itemized statement from the insurance company showing the dates for which premium is being paid, the type of insurance, the dollar amount of the premium; **and**,
* Proof of payment in the form of a pay stub, bank statement showing the debited amount, copy of the completed check or cancelled check, credit card receipt, electronic payment receipt, etc.

***Note to Medicare Enrollees:*** Check here to request automatic recurring monthly reimbursement for Medicare Part B premiums deducted from your Social Security payment. To qualify you must complete this claim form and:

* **You must be signed up to receive reimbursement via direct deposit to your bank account.**
* You must submit a copy of your “Social Security Benefit Verification Letter” or “Annual Notice of Your New Benefit Amount.” (No proof of payment required.)
* Submit this form once at the start of each calendar year, if you have a new plan, if the premium changes or if the coverage ends.

ASIFlex will automatically reimburse you each month for the Medicare Part B premium. Complete the information below to indicate the dates for which you wish to be reimbursed and the monthly amount. See example in red below.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date(s) of**  **Insurance Coverage**  **TO / FROM** | **Insurance Carrier** | **Self or**  **Surviving Spouse** | **Type**  **(Medical, Prescription, Dental, Medicare Part B)** | | **Amount**  **Requested** | **ASIFlex**  **Use Only** |
| **Example: 1/1/23-12/31/23** | **Medicare** | **Member** | **Medicare Part B** | | **$350/month** |  |
|  |  |  |  | | $ |  |
|  |  |  |  | | $ |  |
|  |  |  |  | | $ |  |
|  |  |  |  | | $ |  |
|  |  |  |  | | $ |  |
| **TOTAL** | **$** |  |

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me while I was eligible under the SDCERA HIA and Medicare Part B Reimbursement Plan, and that the premium expenses have not been reimbursed and reimbursement will not be sought from any other source. I understand that if I am eligible to receive a subsidy through the federal health care exchange, I am not able to receive SDCERA reimbursement in addition to lower amounts paid for health insurance premiums. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation.

**SIGN HERE** 🡺 🡺 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_