**SDCERA Health Insurance and Medicare Part B Premium Reimbursement Claim Form**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEMBER’S INFORMATION – Employer: San Diego County Employees Retirement Association** | | | | |
| Name | | | | Social Security Number |
| Mailing Address | | | | Mobile Phone Number  ( ) |
| City | State | ZIP | Email Address | |

|  |  |
| --- | --- |
| **REIMBURSING POST-TAX INSURANCE PREMIUM**  **(NOT MEDICARE):** | **REIMBURSING MEDICARE PART B:** |
| You must include each of the items with this claim form:   1. A bill or letter from your insurance company that shows:    * The dates of your paid coverage    * The type of insurance (medical, dental, etc.)    * How much you paid 2. Proof of payment, such as a pay stub, bank statement, copy of a check, credit card receipt, electronic payment receipt, etc.   Submit this form at the beginning of the year, if you enroll in a new plan, if premiums change, or if coverage ends. | **Your Medicare Part B reimbursements will automatically be deposited at the beginning of each month for the calendar year.**  To qualify, you must include one of these items with this claim form:   * Copy of “Social Security Benefit Verification Letter” OR * Copy of “Annual Notice of New Benefit Amount” |

**Complete the information below to indicate the reimbursement dates and monthly amount. See example in red.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dates of Coverage  TO / FROM | Insurance Company | Type  (medical, dental, etc.) | Amount Requested | ASIFlex  Use Only |
| **Example: 1/1/25-12/31/25** | **Medicare** | **Medicare Part B** | $ **93.50/month** |  |
|  |  |  | $ |  |
|  |  |  | $ |  |
|  |  |  | $ |  |
| 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** è è Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |