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 ➔ ➔ Signature _____ Date _____

FAX:
877.879.9038
PAGE _____ OF _____
NO COVER PAGE REQUIRED

MAIL TO:
ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

FILE ONLINE or by MOBILE APP:
www.ASIFlex.com
Claims may not be submitted by email
Phone 800.659.3035