Administered by Vimly Benefit Solutions
PO Box 6 • Mukilteo, WA 98275
P: 877-808-5994 • F: 866-676-1530 • E: Porac@vimly.com • W: https://porac.simon365.com

CLAIM FORM: for Medical Expense or Premium Reimbursement

Retiree/Beneficiary Name: ________________________________ Date of Birth: ________________________

Street Address: ________________________________ Social Security Number: ________________________

City/State/Zip: ________________________________ Phone Number: ________________________

Email address: ________________________________ Retirement Date ________________________

Instructions to submit claims for reimbursement:

1. Reimbursements will be made directly to the retiree (or other eligible Beneficiary) by check or direct deposit; they cannot be assigned to the provider. Claims are processed once a month and reimbursements are generally issued within 30 days following the receipt of all required documentation.
2. Please submit your medical expenses that are covered by other medical and/or dental plans to those plans first. This will help you preserve this benefit for amounts not covered by other plans.
3. ***Each submission must have supporting documentation in order for a reimbursement to be issued.*** Supporting documentation examples include: CalPERS statements and/or pay stubs reflecting medical/dental premiums, receipts, EOBs, or medical/dental bills.
4. Claims and supporting documentation become the property of the Plan and cannot be returned to you; please make copies as needed before submitting the claim.
5. All expenses must be itemized and allowable under the Plan guidelines. (For a definition of "Covered Expense," please refer to IRS Publication 502). If you are uncertain as to whether an expense is allowable, please contact the Trust Office by phone at (877) 808-5994 or by email at porac@vimly.com.
6. The Plan year runs from July 1 - June 30. **Claims must be submitted within ninety days of the end of the Plan year, i.e., by September 30**.

YOU MUST SIGN THE CERTIFICATIONS ON THE NEXT PAGE OF THIS FORM TO RECEIVE REIMBURSEMENT BENEFTIS.

7. Medical Expenses: Please complete if you are seeking reimbursement for miscellaneous medical expenses (not for premiums). Attach additional pages if necessary.

Service Date	**Provided *For*** (Circle one or more)	Provider	**Type of Service** (Circle one or more)	Amount Requested	Administrator Use Only
	Name:____________________ Self Spouse Dependent		• Medical • Dental • Vision• • Co-Pay • Other • Deductible • Rx	$_______.__	
	Name:____________________ Self Spouse Dependent		• Medical • Dental • Vision• • Co-Pay • Other • Deductible • Rx	$_______.__	
	Name:____________________ Self Spouse Dependent		• Medical • Dental • Vision• • Co-Pay • Other • Deductible • Rx	$_______.__	
			TOTAL REQUESTED	$_______.__	

8. Premiums: Please complete if you are claiming payment for insurance premiums. **You may set up a recurring payment for premiums if you are receiving the monthly lifetime benefit.** If at any time your premium amount changes – up or down – please notify the Trust Office by email to porac@vimly.com. If at any time you wish to terminate this recurring payment, please contact the Trust Office by email to porac@vimly.com.

   PLEASE NOTE: Your recurring payment will automatically terminate on June 30 of each year. If you wish to continue your automatic payments, you must submit a new claim form during June each year to ensure the continuity of your recurring payment.

Type of Premium	**Provided *For*** (Circle one or more)	**Carrier**	**Premium Amount**	**One-time or Recurring Monthly** (Circle one)	**Administrator Use Only**
	Name:______________________________________ Self Spouse Dependent		$_______.__	One-time Recurring Monthly	

9. How do you want to be reimbursed?

   If you have a benefit in both the Pooled and Individual Account, please let us know how much you would like to receive from each account. Please remember the Trust Office will always reimburse you from the pooled amount first.

Pooled	$	Individual Account	$

10. Certifications:

    I certify under penalty of perjury as follows:

- At the time I (or my eligible dependent) incurred the expenses I am claiming, I was not employed by an employer that contributes to the PORAC Retiree Medical Trust. This means also that I was not employed on a part-time or contract basis. I understand that if I return to work, even on a part-time or contract basis, with an employer that contributes to the Trust, I will inform the Trust Office promptly. I understand further that if I start working part-time, I am no longer eligible for benefits, and the Trust could be subject to penalties under federal law. Therefore, I agree that I will advise the Trust Office of part-time employment for any employer that contributes to the Trust. If I fail to do so, I may be subject to recoupment of benefits, penalties and interest.
- The information provided on this form is true, accurate and complete, to the best of my knowledge. I understand that the Plan may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided, e.g. failure to notify the Trust Office if I return to work with an employer that contributes to the Trust.
- The above claim(s) were incurred for services or premiums on behalf of me or my eligible dependent(s).
- I am not eligible for reimbursement, and have not been reimbursed, for the expenses I claim from any other source.
- If I request and receive reimbursement from the Plan for an expense that does not qualify as a Covered Expense under Article I, Section 1.8 of the Plan, I understand that the Plan may pursue legal and equitable remedies and/or recoupment of overpaid benefits against me.
- I understand that expenses for which the Plan reimburses me are not allowed as deductions or credits when filing my individual income tax return.
- I understand that reimbursement payments from the Plan are not taxable income.

____ ______________________________ ____________________________ Retiree

(or other Beneficiary) Signature Retiree (or other Beneficiary) Please Print Date Signed

Claims must be submitted within ninety days of the end of the Plan year, i.e., by September 30

Return your completed Claim Form by mail, fax or email to the Trust Office: **PORAC Retiree Medical Trust, c/o Vimly Benefit Solutions, PO Box 6, Mukilteo, WA 98275**
F: 866-676-1530; E: Porac@vimly.com; W: https://porac.simon365.com