PORAC RETIREE MEDICAL TRUST
Medical Expense Reimbursement Plan
Administered by Vimly Benefit Solutions
PO Box 6 • Mukilteo, WA 98275
P: 877-808-5994 • F: 866-676-1530 • E: PORAC@vimly.com

CLAIM FORM: Medical Expense or Premium Reimbursement

Retiree/Beneficiary Name: _____ Date of Birth: _____

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Phone Number: _____

Email address: _____ Cell Phone: _____

Instructions to submit claims for reimbursement:

1. The Trust will make reimbursement benefit payments directly to the Eligible Retiree (or other eligible Beneficiary) by check or direct deposit; your benefit payment cannot be assigned to a medical provider or insurance carrier. Claims are processed once per month and reimbursement benefit payments 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, vision, and/or dental insurance plans to those plans first. The Trust will pursue recoupment, and other available remedies, for claims submitted in violation of the Plan rules (e.g., for expenses that are paid elsewhere).
3. ***Each claim for reimbursement must have supporting documentation of health care services, supplies or premiums and proof of payment by you in order for the Trust Office to issue a reimbursement benefit payment.*** Supporting proof of payment documentation examples include: CalPERS statements and/or pay stubs reflecting medical/dental/vision premium payments deducted from your pension, receipts from medical providers or insurance carriers, medical/dental/vision bills marked as "paid" by the medical provider, or cancelled checks.
4. Claims and supporting documentation become the property of the Plan and cannot be returned to you; please make copies before submitting the claim, if needed.
5. All expenses must be itemized and qualify as Covered Expenses under the Plan. (For examples of tax-deductible medical expenses that can be reimbursed by this Plan, please refer to IRS Publication 502 at https://www.irs.gov/pub/irs-pdf/p502.pdf). If you are uncertain as to whether an expense is reimbursable, 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. Expenses paid during the Plan year must be postmarked within three months of the end of the Plan year, i.e., by September 30th.
7. **Medical Expenses:** Please complete the following information if you are seeking reimbursement for one-time miscellaneous medical expenses (not for insurance premiums). Attach documentation, and additional pages, if necessary.

Service Date	**Provided *For*** (Circle one or more)	**Service or Supplies Provider**	**Type of Medical Service or Supplies** (circle one or more)	**Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Child		· Dental · Vision· · Premium · Other · Deductible · Rx	$_____.__	
	Name:_____ Self Spouse Child		· Dental · Vision· · Premium · Other · Deductible · Rx	$_____.__	
	Name:_____ Self Spouse Child		· Dental · Vision· · Premium · Other · Deductible · Rx	$_____.__	
			TOTAL REQUESTED	$_____.__	

8. **Premiums:** Please complete the following information if you are claiming reimbursement for payment of insurance premiums. You need to submit this Claim Form to the Trust Office annually along with third-party documentation of the type of coverage, amount of premium and period of insurance coverage, and proof of payment of the insurance premiums in order to request reimbursement of your monthly insurance premiums. **You need to submit proof of payment of each monthly premium that you want reimbursed (12 monthly payments, unless you pay your insurance premium on some other frequency) prior to receiving reimbursement for each monthly premium.** If you are claiming reimbursement of Medicare premiums, you generally only need to provide your Social Security statement showing the Medicare deduction once per year with this Claim Form. You must provide a new Claim Form and new third-party documentation of the type of coverage, amount of premium, and period of coverage, at least annually and any time your premium amount (including Medicare premium) changes (i.e. increases or decreases).

9.

Type of Premium	**Provided *For*** (Circle one or more)	**Insurance Carrier**	**Premium Amount**	**Administrator Use Only**
	Name:_____ Self Spouse Child		$_____.__	
	Name:_____ Self Spouse Child		$_____.__	
	Name:_____ Self Spouse Child		$_____.__	

10. How do you want to be reimbursed?
If you are entitled to a regular monthly benefit as a Regular Beneficiary and also have an Individual Account benefit, please let us know how much you would like to receive from each benefit. If you do not instruct us otherwise on this Claim Form, the Trust Office will reimburse you from your regular monthly benefit first (up to your monthly Benefit Level) and then reimburse the remainder from your Individual Account (up to the balance in your Individual Account).

Regular Monthly Benefit	$	Individual Account	$

11. Certifications and Agreements of Beneficiary:
- I certify that the above claim(s) were incurred for services or premiums on behalf of me or my eligible Beneficiaries. These expenses have not been reimbursed, and I will not seek reimbursement, from any other source.
- If I request and receive reimbursement from the Trust for an expense that does not qualify as a Covered Expense under Plan Section 1.8, I understand that the Trust may pursue recoupment of overpaid benefits.
- I understand that the benefits paid to me by the Trust cannot exceed the actual premiums and/or medical expenses paid by eligible Beneficiaries. I understand that I am responsible for all premium payments to the insurance carrier(s) and medical providers and that the Trust will reimburse me - not the insurance carrier or medical provider.
- **I understand that at least annually I will be required to furnish a new Claim Form and new third-party documentation of my insurance coverage and premiums. I understand that I must submit proof of payment of each insurance premium prior to receiving reimbursement of that premium.**
- I understand that expenses for which the Plan reimburses me are not allowed as deductions or credits when filing my individual income tax return and benefit payments from the Plan are not taxable income.

- **I affirm that I am not currently employed by a Trust Participating Employer[1] (including part-time or contract work) and was not employed by a Participating Employer when the attached expenses were incurred**. **I affirm that I do not intend to start employment with a Participating Employer within the next year, and if I do, I will inform the Trust Office prior to my first day of work.** I acknowledge that this Plan is a retiree-only plan, and therefore, a Beneficiary cannot receive benefits while employed by a Participating Employer. I understand that my benefits will be suspended during a period of employment with a Participating Employer, and the Trust could be subject to penalties under federal law, if benefits are paid during that employment. Benefit payments can resume when all employment with Participating Employers has ceased.
- I understand that the Plan may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided on this Claim Form. I agree to indemnify and reimburse the Trust on demand for overpayment of benefits, and any liabilities or damages incurred, as a result of a fraudulent claim payment.

I certify under penalty of perjury that I have read this Claim Form and all information on this Claim Form is true, accurate and correct, to the best of my knowledge.

_____	_____	_____
Retiree (or other Beneficiary) Signature	Relationship to Retiree	Date Signed

Additional Contact information if we are not able to reach you: _____

NAME CELL PHONE NUMBER EMAIL

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
P: 877-808-5994
F: 866-676-1530; E: Porac@vimly.com

[1] A list of Participating Employers is available on the Trust web portal at https://PORAC.simon365.com.