Santa Monica City Employees Coalition Benefit Trust
SMCECBT

Administered by:
Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
Telephone (800) 828-0223
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BENEFIT CLAIM FORM

Plan Participant Name: _____

Spouse's Name: _____

Address: _____

_____

Date of Retirement or Termination of Employment: _____

Date of Birth: _____ Social Security Number: _____

Daytime Phone #: _____ E-mail Address: _____

1) Reimbursement Limited to Premium Paid. As a Beneficiary in the Premium Reimbursement Plan for Retirees (Plan) of the Santa Monica City Employees Coalition Benefit Trust (Trust), I understand that I am entitled to a monthly reimbursement benefit for insurance premiums that I have paid. I understand that the monthly benefit that the Trust pays cannot exceed the actual premium expenses paid by the Beneficiary. I have elected to receive reimbursement of health (medical, dental, prescription drug, vision, Medicare, Medicare supplemental, long-term care) insurance premiums, as stated on page two.

2) Pre-tax Premiums Not Reimbursable. I understand that insurance premiums paid pre-tax are not reimbursable by this Plan. (Payment "pre-tax" means that you paid the premium with income that is not taxable to you, e.g., the premium amount was deducted from your spouse's income prior to taxation. For example, your spouse paid a premium through your spouse's cafeteria plan at his/her job, and that amount of your spouse's salary won't be taxable income to you or your spouse.) I am not submitting for reimbursement of any insurance premiums that were paid pre-tax by an employer or deducted from payroll pre-tax.

3) Duty to Notify Trust of Change in Premiums. I understand that, based on the information I provide herein, the Trust will make payments to me to reimburse my premium payments. I agree to notify the Trust within 30 days of termination, reduction or increase of any of the claimed insurance premiums. If my premium amount changes, I understand that I will need to submit a new Benefit Claim Form and insurance documentation. If I am reimbursed for premiums that I did not pay, I will reimburse the Trust for any overpayments to me, including penalties and interest, and if I do not repay any overpaid benefits, I understand that the Trust has the right to offset future benefit payments in order to recoup these overpayments.

4) Verification of Premiums. I understand that, before I can receive reimbursement payments for

monthly premiums paid for coverage in a particular calendar year, I must: (1) sign this Form and returned it to the Trust Office; (2) along with written documentation from my insurance carrier or plan showing coverage type, effective date, and premium amount; and (3) provide proof of my payment of the premiums. **I understand that I must provide new documentation of premiums annually and within 30 days of any change in premium.**

5) Medicare Enrollment. **I understand that I am required to furnish new verification of my medical insurance premiums (as described in #3 above) upon attaining eligibility for Medicare.** If I have not provided new verification of medical insurance premiums by my 65th birthday, then I understand that the Trust Office will suspend my premium reimbursement payments for medical insurance premiums starting the month after my 65th birthday until such documentation is received at the Trust Office.

6) Benefit Amount May Be Adjusted. I understand that my monthly benefit is determined based upon the Benefit Amount set and reviewed periodically by the Trustees, and that the Trustees may adjust the Benefit Amount, or other provisions of the Plan, from time to time, which may affect my monthly benefits.

7) Income Tax Deductions Prohibited. I understand that these benefit payments are not taxable, and therefore, the premium amount reimbursed is not allowed as a deduction when filing my individual income tax return. I understand that I am responsible for any income tax penalties incurred related to improper deduction of insurance premiums reimbursed pursuant to this claim. However, due to federal law, benefit payments reimbursing premiums for coverage of a Domestic Partner are taxable, and I understand that I will receive a Form 1099 for the imputed taxable income from this portion of my benefit payment, if any.

I am enrolled in the following insurance coverage with the following premiums (a copy of third-party documentation of each premium, as described in #4 above, is attached along with proof of my payment of the premium):

☐ Medical: _____

(includes Medicare Part B and Medicare Supplemental)

Monthly Premium $____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

Monthly Premium $____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Dental: _____

Monthly Premium $____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Vision: _____

Monthly Premium $____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Drug: _____

(includes Medicare Part D)

Monthly Premium $____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Other (includes long-term care): _____

Monthly Premium $____ Effective Date:_____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

Total Monthly Premium Reimbursement Requested $_____

8) Premium Payment to Insurance Carrier. I understand that I am responsible for all premium payments to the insurance carrier(s) and that the Trust will reimburse me - not the insurance carrier.

9) Claims Limited to Plan's Definition of Premiums. If I request and receive reimbursement from the

Trust for an expense that does not qualify as a Premium under Plan Section 1.17 (i.e., tax-deductible premium), then I understand that the Trust may pursue recoupment of overpaid benefits and penalties for failure to withhold taxes.

10) Fraudulent Claims. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided, e.g. failure to advise the Trust of termination of coverage or change in premium.

11) Suspension of Benefits During Re-employment with City of Santa Monica. I affirm that I am not currently employed by the City of Santa Monica (including part-time or contract work) and was not employed by the City of Santa Monica when the claimed expenses were incurred. I affirm that I do not intend to start employment with the City of Santa Monica within the next year, and if I do, I will inform the Trust Office prior to my first day of work.

I certify under penalty of perjury that the information I have given above is true and correct, and that I have read and understood all information included in this Benefit Claim Form.

_____ _____

Eligible Retiree or Surviving Spouse/Child Signature Date