Administered by:
Benefit Programs Administration
1200 Wilshire Boulevard, Fifth Floor
Los Angeles, CA 90017-1906
Telephone (800) 828-0223
Fax (562) 463-5894

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 actual Benefit Level paid by the Trust cannot exceed the actual premium expenses paid by the Beneficiary. I have elected to receive reimbursement of health (medical, dental, prescription drug, vision, long-term care) insurance premiums, as stated on page two.

2) Change in Premiums. I understand that, based on the information I provide herein, the Trust will make payments directly to me to reimburse me for my premium payments. I agree to notify the Trust within thirty (30) days of termination or reduction of any of the claimed insurance premiums. If I fail to do so, I will be obligated to reimburse the Trust for any overpayments to me, as well as to pay the Trust for penalties and interest.

3) Annual Verification. I understand that the premium reimbursement will not commence until I have signed this form and returned it to the Trust Office, with written documentation from the insurance carrier showing coverage type, effective date, and premium amount, and proof of my payment of the premiums. I understand that once a year I will be required to furnish new verification of my insurance premiums and proof of payment, or more often if deemed necessary by the Trust.

4) Benefit Amount May Be Adjusted. I understand that my monthly Benefit Level 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 Benefit Level.

I am enrolled in the following plan(s) with the following premiums (a copy of each premium invoice 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 $_____

5) 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.

6) I understand that reimbursement is available only for a Premium as defined in Article I, Section 1.17 of the Plan. I agree to notify the Trust Office if I have any reason to believe that a reimbursement I received was not for a Premium.

7) I agree to promptly notify the Trust Office of date of death of any Beneficiary whose premium is claimed on this Benefit Claim Form.

8) I agree to indemnify and reimburse the Trust on demand for any liability it may incur for failure to withhold federal, state or local income tax from any reimbursement I receive of a non-qualifying premium up to the amount of additional tax actually owed by me, i.e, if I request and receive reimbursement from the Trust for a payment that does not qualify as a Premium under the Plan.

I certify under penalty of perjury that the information I have given above is true and correct, and that I have read this form. 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.

_____ _____

Eligible Retiree or Surviving Spouse/Child Signature Date

_____ _____

Spouse's Signature (if claim by Eligible Retiree) Date