Administered by:
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906

Santa Monica City Employees Coalition Benefit Trust
SMCECBT

Phone: (800) 828-0223
Fax: (562) 463-5894
E-mail: santamonicacity@bpabenefits.com
Website: www.smcecbt.org

BENEFIT CLAIM FORM

Plan Participant Name: _____

Spouse's Name: _____

Address: _____

_____

Date of Retirement or Termination of Employment: _____

Daytime Phone #: _____ E-mail Address: _____

1) Election of Coverage(s). As a Beneficiary in the Premium Reimbursement Plan (Plan) of the Santa Monica City Employees Coalition Benefit Trust (Trust), I believe that I am entitled to a monthly premium reimbursement Benefit Amount not to exceed $350.00, for insurance premium payments that I make. I understand that the actual Benefit Amount paid by the Trust cannot exceed the actual premiums paid by the Beneficiary. I have elected to enroll in group or individual health (medical, dental, prescription drug, vision) coverage, as described on page two.

2) Reimbursement. 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. If my premium payments change or terminate, for any reason, it is my obligation to promptly advise the Trust of same. 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 confirmation by the insurance carrier showing coverage type, effective date, and premium amount. **I understand that once a year I will be required to furnish verification that these insurance policies remain in effect, or more often if deemed necessary by the Trust**.

4) Benefit Amount May Be Adjusted. I understand that the Trustees shall set my Benefit Amount, and that the Trustees may adjust the Benefit Amount, or other provisions of the Plan, from time to time.

I am enrolled in the following plan(s) (proof for each premium amount listed below is attached):

☐ Medical: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Dental: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Vision: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Drug: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

☐ Other: _____

Monthly Premium $ _____ Effective Date: _____ Policy Number: _____

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 carrier.

6) I understand that reimbursement will be available only for premiums as defined in Article I, Section 1.15 of the Plan.

7) I agree to notify the Trust within thirty (30) days of termination or reduction in premium of any of the foregoing policies.

8) I agree to notify the Trust if I have reason to believe that any reimbursement I have received was not for a premium.

9) I also 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 expense or premium up to the amount of additional tax actually owed by me, i.e, if I request and receive reimbursement from the Trust for an expense that does not qualify as a premium under in Article I, Section 1.15 of 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.

_____ _____

Participant's Signature Date