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 monthly benefit 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, Medicare, Medicare supplemental, 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 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 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 at least once a year I will be required to furnish new verification of my insurance premiums and proof of payment.**

4) 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.

5) Income Tax Deductions. I understand that these benefit payments are not taxable, and therefore, expenses reimbursed are not allowed as deductions when filing my individual income tax return. 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 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 $__________________

6) 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.

7) 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.

8) 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.

9) 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 attached 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. If this Form was signed after January 1, 2021, and I was retired on January 1, 2021, I affirm that I was not employed by the City of Santa Monica on January 1, 2021.

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

______________________________ ______________________

Eligible Retiree or Surviving Spouse/Child Signature Date