

2012

SDCERA

Strength. Service. Commitment.

Health Insurance Reimbursement Request form
For Retired Tier I and Tier II Members

Health Insurance Reimbursement Request form instructions

Eligible Tier I and Tier II retired members who enroll in a medical, dental or prescription plan not sponsored by SDCERA may request a reimbursement for the cost of the insurance premium, up to the retired member's monthly health insurance allowance amount. For information on allowance eligibility, please review the *Health Insurance Allowance* fact sheet available from SDCERA.

Eligible for reimbursement

- Privately secured health insurance
- Health insurance through spouse or employer
- Health insurance through the military
- COBRA/Cal-COBRA premiums

Not eligible for reimbursement

- Retroactive payments
- Coverage for non-SDCERA members
- Annual deductibles
- Co-pays
- Prescriptions
- Long-term custodial care
- SDCERA group plan premiums
- Medicare Part B premiums

Do not complete this form to request dental reimbursement if:

- you enroll in a dental plan offered by Retired Employees of San Diego County (RESDC); or
- you enroll in a dental plan offered by Deputy Sheriffs' Association (DSA)

Your reimbursement will be processed by separate authorization from those agencies.

SECTION 1: EVENT TYPE

Make only one selection. Review the following to determine which event to select.

• Open Enrollment

You must submit a new *Health Insurance Reimbursement Request* form each year during Open Enrollment (unless you have coverage through RESDC or DSA as explained above). This selection only applies during the annual Open Enrollment period each year in November and becomes effective January 1 of the following year.

• Initial Request

If you are not currently receiving an SDCERA health insurance reimbursement, this is your initial request. Your initial request can be made at any time throughout the year.

• Plan/Premium Change

If your current plan or premium amount changes, you must report the change to SDCERA within 30 days following the effective date of the change, because your reimbursement amount may need to be adjusted. This adjustment request can be made at any time throughout the year. If you are enrolled in a RESDC dental plan or a DSA dental plan it is not necessary to submit premium amount changes because SDCERA is able to confirm those changes.

SECTION 2: MEMBER INFORMATION

Complete all information in this section—please print clearly.

SECTION 3: PLAN INFORMATION

Complete this section by indicating the name of the medical, dental and/or prescription plan. Indicate whether the SDCERA member is the policy holder or dependent on the plan and the most recent effective date of the policy or the date the coverage begins.

Write in the amount of the monthly premium cost paid to cover the SDCERA member. Many insurance plans cover more than one person. Remember, SDCERA only reimburses for the cost of the SDCERA member's coverage, not for the cost of other family members.

Verification of premium must include a breakdown of the premiums for the plan showing the cost for the policy holder separately from the cost of dependents (if any).

You are required to attach documentation verifying:

- Proof of coverage
- Proof of premium cost and
- Proof of payment

This form will be processed only if the required documentation is attached. The reimbursement is effective the first day of the month that SDCERA receives valid documentation.

Examples of acceptable documentation

Submit one of each (for each type of insurance):

Proof of coverage

- Most recent invoice or billing statement showing your name and the effective date of the coverage, or
- A signed letter from your insurance company or employer, or
- Plan identification card (copy of front and back)

Proof of premium cost

- Letter from the carrier or the employer stating the SDCERA member's portion of premiums, less the employer's contribution, or
- Most recent invoice or billing statement stating the SDCERA member's portion of premiums, less the employer's contribution

Proof of payment

- Most recent pay stub showing the deduction, or
- Most recent canceled check (copy of front and back), or
- Most recent bank statement showing the account holder's name with the payment amount circled, or
- Letter from carrier or employer stating the payment has been made

SECTION 1: EVENT TYPE *Make only one selection. See attached instructions before completing this section.*

Open Enrollment
 Initial Request
 Plan / Premium Change

SECTION 2: MEMBER INFORMATION

First name	MI	Last name	Social Security number
Street address			
City	State	ZIP	Daytime telephone number ()

SECTION 3: PLAN INFORMATION *This form will be processed only if required documentation verifying proof of coverage, proof of premium and proof of payment is provided. See instructions for acceptable forms of required documentation.*

Attach proof of coverage, proof of premium cost and proof of payment for each type of insurance plan here. The attached proofs must support the total monthly costs entered on the form.

MEDICAL PLAN NAME	Most recent effective date of policy or change:	Monthly cost for SDCERA member's coverage
Is the SDCERA member the policy holder or dependent? <input type="radio"/> Policy holder <input type="radio"/> Dependent	Number of people (including yourself) covered by this plan:	\$
Is 100% of the monthly premium paid by you? <input type="radio"/> Yes <input type="radio"/> No	If no, please explain:	<i>Do not include cost for others covered by this plan.</i>
DENTAL PLAN NAME	Most recent effective date of policy or change:	Monthly cost for SDCERA member's coverage
Is the SDCERA member the policy holder or dependent? <input type="radio"/> Policy holder <input type="radio"/> Dependent	Number of people (including yourself) covered by this plan:	\$
Is 100% of the monthly premium paid by you? <input type="radio"/> Yes <input type="radio"/> No	If no, please explain:	<i>Do not include cost for others covered by this plan.</i>
PRESCRIPTION PLAN NAME	Most recent effective date of policy or change:	Monthly cost for SDCERA member's coverage
Is the SDCERA member the policy holder or dependent? <input type="radio"/> Policy holder <input type="radio"/> Dependent	Number of people (including yourself) covered by this plan:	\$
Is 100% of the monthly premium paid by you? <input type="radio"/> Yes <input type="radio"/> No	If no, please explain:	<i>Do not include cost for others covered by this plan.</i>

SECTION 4: AUTHORIZATION

I have read and understand the information and instructions provided with this form. I certify, under penalty of perjury, that the information provided is correct. I understand that the health insurance allowance used for the reimbursement requested on this form is not guaranteed and may be reduced or eliminated at any time.

I understand if I choose a plan other than an SDCERA-sponsored plan, my coverage may be different than if I had selected an SDCERA-sponsored plan. Another plan may require me to prove my good health or may exclude pre-existing conditions. My health insurance reimbursement covers only medical, dental and/or prescription insurance premiums that are paid for my individual coverage and cannot be used to purchase Medicare Part B. I further understand that my health insurance reimbursement will be reported to the Internal Revenue Service (IRS) on *Form 1099-R* as nontaxable income. If the IRS requires any tax payment from the health insurance reimbursement I receive, I understand that I am responsible for all taxes.

The coverage I have indicated in Section 3 is currently in effect and I agree to notify SDCERA immediately if my plan(s) or premium(s) cease or change. If I receive a reimbursement in excess of the actual cost of my coverage, I agree to repayment terms determined by SDCERA.

Signature **X** Date

