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

Office: (833) 728-2747
Fax: (562) 463-5894
E-mail: centralvalley@bpabenefits.com

Medical Expense or Premium Reimbursement Claim Form

Retiree/Beneficiary Name: _____ Date of Birth: _____

Street Address: _____ Social Security Number: _____

City/State/Zip: _____ Phone Number: _____

Email address: _____ Cell Phone Number: _____

Instructions to submit claims for reimbursement:

1. ***Each claim for reimbursement must have supporting documentation of health care services, supplies or premiums and proof of payment by you in order for the Trust Office to issue a reimbursement payment.*** Examples of proof of payment include: CalPERS statements of health care premiums deducted from your pension payment; receipts from medical providers or insurance carriers; or cancelled checks for medical/dental/vision expenses or premiums.
2. Claims and supporting documentation become the property of the Plan and cannot be returned to you; please make copies as needed before submitting the claim.
3. Please itemize all expenses below. All claims must be for a Covered Expense under the Medical Expense Reimbursement Plan("Plan"). (For a definition of "Covered Expense," please refer to Article I, Section 1.8 of the Plan.) If you are uncertain as to whether an expense is reimbursable, please contact the Trust Office by phone at (833) **728-2747** or by email to **centralvalley@bpabenefits.com.**
4. You must submit your written claims no later than January 31st of the year following the date on which the eligible Beneficiary made the payment for the Covered Expense, unless you are submitting a claim for payment from an Individual Account, which has no claims deadline.
5. We suggest that you submit medical expenses that are covered by another medical and/or dental plan to those plans first before requesting reimbursement from this Plan. This process ensures that this Plan is only reimbursing for costs that you will actually have to pay. In addition, it will help you preserve your benefits from this Plan for amounts not covered by other plans. The Trust will pursue recoupment, and other available remedies, for claims submitted in violation of the Plan rules (e.g., for expenses that are paid elsewhere).
6. Reimbursements will be made directly to the retiree (or other eligible Beneficiary) by direct deposit; reimbursement payments cannot be assigned to the medical service provider. The Trust Office will process claims once a month, and generally issues payment within 30 days after receipt of all required documentation.

YOU MUST SIGN THE CERTIFICATIONS ON THE NEXT PAGE OF THIS FORM TO RECEIVE REIMBURSEMENT BENEFIT PAYMENTS.

Please complete this Section if you are seeking reimbursement for one-time expenses. Attach additional pages if necessary.

Service Date/Premium Period	**Provided *For*** (Circle one or more)	**Provider/Carrier**	**Type of Coverage/Service**	**Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Dependent		· Medical · Dental · Vision· · Premium · Co-Pay · Other · Deductible · Rx	$_____.__	
	Name:_____ Self Spouse Dependent		· Medical · Dental · Vision· · Premium · Co-Pay · Other · Deductible · Rx	$_____.__	
	Name:_____ Self Spouse Dependent		· Medical · Dental · Vision· · Premium · Co-Pay · Other · Deductible · Rx	$_____.__	
			TOTAL REQUESTED	$_____.__	

Please complete the following Section if you are requesting a recurring claim payment for insurance premiums. If at any time your recurring premium amount changes – up or down – or you wish to terminate this recurring payment, you must notify the Trust Office by email to centralvalley@bpabenefits.com.

Type of Premium	**Provided *For*** (Circle one or more)	**Carrier**	**Premium Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Dependent		$_____.__	
	Name:_____ Self Spouse Dependent		$_____.__	
	Name:_____ Self Spouse Dependent		$_____.__	

PLEASE NOTE: Your recurring claim request will automatically terminate on December 31 of each year. If you wish to continue your recurring monthly reimbursement payments, you must submit a new claim form (with new supporting documentation of current year premium amounts) each year by April 1 in order to avoid suspension of your recurring reimbursement payment.

Certifications and Agreements of Beneficiary

a. I certify under penalty of perjury that the foregoing information is true and correct, to the best of my knowledge.
b. I certify that the above claim(s) were incurred for services or premiums on behalf of me or my eligible Beneficiaries. These expenses have not been reimbursed, and I will not seek reimbursement, from any other source.
c. 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.
d. If I request and receive reimbursement from the Trust for an expense that does not qualify as a Covered Expense under Article I, Section 1.8 of the Plan, I understand that the Trust may pursue recoupment of overpaid benefits.
e. 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.
f. I understand that at least annually I will be required to furnish new verification of my insurance premiums and proof of payment.
g. I understand that expenses for which the Plan reimburses me are not allowed as deductions when filing my individual income tax return.
h. I agree to promptly notify the Trust Office of date of death of any Beneficiary whose premium is claimed on this Benefit Claim Form.
i. I affirm that I am not currently working (including part-time or contract work) for any Trust participating employer, and was not working for a participating employer when the attached expenses were incurred.

_____ _____ _____
Retiree (or Beneficiary) Signature (Required) Print Name Date Signed

_____ _____ _____
Spouse's Signature (if claim by Eligible Retiree) Print Name Date Signed