

Emeriti Retirement Health Solutions Qualified Medical Expense Claim Form

This form is used to submit claims for Qualified Medical Expenses (QME) under your institution's Emeriti Retiree Health Plan (Plan). Multiple claims submitted together in one envelope are treated as a single submission. A single submission can consist of claims for yourself, your spouse, and/or qualified dependents. Your first four submissions per calendar year are processed free of charge. Each submission thereafter for the rest of the calendar year will incur a \$6 charge, assessed to your health account, prior to the claim being paid.

Please review your claim submission carefully. All claims must be received in good order (with the claim form filled out in its entirety and accompanied by proof of payment).

Qualified medical expense reimbursements are paid out twice a month.

If your claim is received by the Friday before the 7th of the month, you will receive a reimbursement check around the third week of that month.

If your claim is received by the Friday before the 25th of the month, you will receive a reimbursement check around the first week of the following month.

INSTRUCTIONS:

- **Please keep copies of this form and all backup documentation in the event that your claim requires additional information for processing.**
- Use this form to request reimbursement for medical and long-term care expenses, premiums for health insurance not provided by the Plan, premiums for long-term care insurance, or premiums for Medicare. Reimbursement applies to expenses and premiums incurred by you, your spouse, or your eligible dependents that have been designated under the Plan. Expenses must be submitted for reimbursement within 12 months following the end of the calendar year in which the expense was incurred.
- A single QME claim totaling \$100,000 or more must be accompanied by a Signature Guarantee. Signature Guarantees are available from banks, credit unions, and brokerage firms.
- If you have a Health Spending or Flexible Spending Account through the employer sponsoring this Plan, you must exhaust those accounts before requesting reimbursement through this Plan (some exceptions apply).
- To determine your eligibility to request a QME, or for additional information regarding the Plan, please refer to the Summary Plan Description.
- Checks are mailed to the address on record with your Emeriti account. Please call **1-866-EMERITI** (1-866-363-7484), Monday through Friday, 8 a.m. to 9 p.m. Eastern time, to update or confirm the address on record, to inquire about or update qualified dependents, or to obtain available balance information.
- If you have any questions about your QME claim, call Acclaris toll free at **1-800-317-0559**, Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Your form and supporting documents can be submitted by either fax or mail.

**Fax to:
1-866-830-1639**

OR

**Mail to:
Acclaris
PO Box 20571
Tampa, FL 33622-0571**

EMERITI QUALIFIED MEDICAL EXPENSE CLAIM FORM

1. Account Holder Information:

Name:

Social Security #: - -

Street Address:

City: State: Zip: -

Daytime Phone: - - Ext:

2. If any claims are being submitted for anyone other than, or in addition to, the Account Holder, please provide the information below:

Name:

Social Security #: - -

Street Address:

City: State: Zip: -

Daytime Phone: - - Ext:

3. Please itemize each expense in the chart below.

- Each expense must be accompanied by proof of payment: a receipt or Explanation of Benefits (EOB). Canceled checks or credit card statements are not acceptable receipts.
- Each receipt or EOB must show the Provider's Name, Patient's Name, Date of Service or Purchase, Expense Amount, Service, Treatment, and Medication or Supply Name. For over-the-counter medications or medical supplies, the receipt need only specify the date of purchase and the medication or supply name.

Date(s) of Service	Service Provider (Name of Clinic, Doctor, Pharmacy, Store, etc.)	Description of Expense (Ex.: Long Term Care Premium, OTC Drugs, Co-Payment)	Service Recipient Name	Indicate If Service Recipient Is Self, Spouse, or Qualified Dependent	Requested Reimbursement Amount
TOTAL REIMBURSEMENT REQUESTED (Proof of payment of this amount must be submitted with claim form.)					

If additional space is needed, please provide all requested information from the grid above on a separate sheet of paper for each additional claim.

EMERITI QUALIFIED MEDICAL EXPENSE CLAIM FORM (CONTINUED)

4. If applicable, please check whether this claim and the expenses itemized below are for:

- Catastrophic Expenses Terminal Illness

5. Certification and Signature. I certify that the expenses for reimbursement requested above were incurred by me (and/or my spouse, and/or dependent domestic partner, and/or eligible dependents, as defined in tax code Section 213d) and that the description of these expenses is accurate and meets the guidelines specified under Internal Revenue Code Section 213d, and supporting IRS Regulations, or for the payment of Long-Term Care Insurance premiums. I certify that any over-the-counter medication or allowable medical supply requested above was purchased for my (and/or my spouse's, and/or dependent domestic partner's, and/or eligible dependent's, as defined in tax code Section 213d) medical care and was not purchased for general good health. I further declare that these expenses have not previously been reimbursed to me nor will I seek reimbursement from any other plan covering health benefits. I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information is guilty of a crime and may be liable for substantial civil penalties. I hold Acclaris, its affiliated companies, officers, and employees harmless for payment of any ineligible expenses presented in such a manner.

Signature: _____ Date: _____

If this form is being completed by a legal representative of the recipient (e.g., guardian, power of attorney, executor), please provide the basis of authority.

Basis of Authority: _____

- Before submitting this form, did you...**
- complete the form in its entirety?
 - sign the form in Section 5?
 - include the total amount of reimbursement requested in Section 3?
 - include proof of payment for all claims being submitted?