Emeriti Retirement Health Solutions

Qualified Medical Expense (QME) Claim Form

Please use this Claim Form to submit claims for the reimbursement of Qualified Medical Expenses, otherwise known as the Emeriti Reimbursement Benefit, under your (former) employer's Emeriti Retiree Health Plan ("Plan"). Before you complete and submit this Claim Form, please read the accompanying document entitled Frequently Asked Questions carefully. Be sure to provide all requested information, substantiate your claim(s) by providing proof of payment, and sign the form. If your claim is denied, you will be informed by mail. You will be provided the reason for a denial and an opportunity to appeal or resubmit your claim.

IMPORTANT STEP BEFORE YOU SUBMIT A CLAIM:

Reimbursement claims are paid only from assets in your Emeriti Health Account that are invested in the TIAA-CREF Money Market Fund.

- To transfer money into the Money Market Fund or set-up monthly transfers, please call 1-866-EMERITI (1-866-363-7484) and press option #3.
- You may also log in to your TIAA-CREF account at tiaa- cref.org and follow the instructions.

EMERITI REIMBURSEMENT BENEFIT - CLAIM FORM FOR QMEs

1. Participant (Account Holder) Information.

Name: ____

Institution:____

Social Security Number: _______-_____-_________

Street Address: ____

City: _________________ State: ____ Zip: ________-_____

Daytime Phone: ____-___-_____ Ext: ________

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2. Participant Eligibility.

I am eligible to receive reimbursement benefits because:

- o I no longer work for the employer sponsoring the Plan

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3. List of Qualified Medical Expenses. Enter each QME claim in the chart below. If additional space is needed, please provide all requested information from the grid below on a separate sheet of paper.

	Service/Product Recipient (i.e. Patient)						
Date of Service/Purchase	**Name**	**SSN**	**Relationship to Participant* (must check one box)**	**Date of Birth**	**Service/Product Provider's Name (e.g. Doctor, Pharmacy, Clinic)**	**Type of Expense (must check one box)**	**Requested Reimbursement Amount**
○ Set up as recurring claim			○ Myself ○ Spouse ○ Dependent Child ○ Dependent Domestic Partner ○ Non-Dependent Domestic Partner** ○ Dependent Relative ○ Surviving Spouse ○ Surviving Child			○ Rx Drugs ○ Medical Care ○ Dental Care ○ Vision Care ○ Insurance Premium ○ Other	
○ Set up as recurring claim			○ Myself ○ Spouse ○ Dependent Child ○ Dependent Domestic Partner ○ Non-Dependent Domestic Partner** ○ Dependent Relative ○ Surviving Spouse ○ Surviving Child			○ Rx Drugs ○ Medical Care ○ Dental Care ○ Vision Care ○ Insurance Premium ○ Other	
○ Set up as recurring claim			○ Myself ○ Spouse ○ Dependent Child ○ Dependent Domestic Partner ○ Non-Dependent Domestic Partner** ○ Dependent Relative ○ Surviving Spouse ○ Surviving Child			○ Rx Drugs ○ Medical Care ○ Dental Care ○ Vision Care ○ Insurance Premium ○ Other	

* Please refer to the separate Frequently Asked Questions document regarding who qualifies as an eligible "Plan Dependent."

** Please note that reimbursed claims for non-dependent domestic partners are taxable distributions from the Plan. Please refer to Frequently Asked Questions for details.

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4. Proof of Payment.

You must submit proof of payment for each Qualified Medical Expense, which may be (i) an Rx label, (ii) an insurance billing statement, (iii) an Explanation of Benefits (EOB), or (iv) an itemized bill for medical services rendered. *Please refer to the Instructions and Additional Information below for details.*

5. Certification and Signature.

By my signature below I hereby certify and/or acknowledge the following:

1) The Qualified Medical Expenses identified above were incurred by me and/or my eligible Plan Dependent(s). Any prescribed medication or allowable medical supply requested above was purchased for me and/or my eligible Plan Dependent(s) and was not purchased for general good health.
2) I am solely responsible for the correct designation of my eligible Plan Dependents, and I have made such designation(s) herein in compliance with the terms of my Plan and the Summary Plan Description. I understand that if I make such designation incorrectly, either by error or intent, that I will be responsible for refunding to the Plan any associated ineligible QME reimbursements I received as soon as practicable following the discovery of such incorrect designation of a Plan Dependent.
3) To the extent I am submitting a request for the reimbursement of an expense incurred by my dependent domestic partner, as indicated by me in Section 3 above, I certify that such individual maintains residence in my home as his or her principal place of abode and is a member of my household. Further, I certify that such individual receives over half of his or her support from me, and is covered under the terms of my Plan.
4) To the extent I am submitting a request for the reimbursement of an expense incurred by my non-dependent domestic partner, as indicated by me in Section 3 above, I certify that such individual maintains residence in my home as his or her principal place of abode and is a member of my household, and is covered under the terms of my Plan.
5) To the extent I am submitting a request for the reimbursement of an expense incurred by a dependent relative, as indicated by me in Section 3 above, I certify that such individual (a) receives over half of his or her support from me, and (b) is either (i) my child or a descendant of a child, sibling, stepsibling, parent, ancestor of my parent, stepparent, aunt, uncle, niece, nephew, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, irrespective of whether living in my home, or (ii) and individual who maintains residence in my home as his or her principal place of abode and is a member of my household, and is covered under the terms of my Plan.
6) If I receive a reimbursement benefit for a claim incurred by a Plan Dependent who is not eligible to be treated as my dependent under the Internal Revenue Code (such as a non-dependent domestic partner), I understand that such reimbursement will be taxable under the Internal Revenue Code.
7) These expenses for which I am seeking reimbursement have not previously been reimbursed to me (or a Plan Dependent) by any other plan covering health benefits, nor will I (or a Plan Dependent) seek such reimbursement.
8) I am not currently covered under a Flexible Spending Arrangement (a “FSA”) under Internal Revenue Code Section 125 (a “cafeteria plan”), or if I am covered under a FSA for the applicable period, I have exhausted my maximum annual coverage for the year in which the expenses were incurred.
9) I am not currently enrolled in a Health Savings Account (an “HSA”), or if I am enrolled in an HSA, I have first satisfied the high deductible health plan’s annual deductible for the year for which the expense was incurred.
10) To the extent my claim is for the reimbursement of insurance premiums, if I (or an eligible Plan Dependent) receive(s) a full or partial refund of a reimbursed premium from any medical provider or insurance company, after being reimbursed by my Plan, I am obligated to return the refunded amount to my Emeriti Health Account.
11) I further certify that I understand that any person who, knowingly and with intent to defraud or deceive, files a claim containing any materially false, incomplete or misleading information may be prosecuted under state law and be subject to civil fines and criminal penalties. I hold Savitz, its affiliated companies, officers, and employees, Emeriti Retirement Health Solutions, its officers and employees, TIAA-CREF Trust Company, its affiliated companies, officers and employees, and my Plan harmless for payment of any ineligible expenses presented in such a manner under the terms and conditions of the Emeriti Reimbursement Benefit.

Signature: ______________________________________ **Date**: _____________

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6. Legal Representative.

If this Claim Form is being completed by a legal representative of the Participant (e.g., guardian, individual with power of attorney, executor), please submit appropriate proof for basis of authority with this claim.

Basis of Authority: ____
Name: ____
Address: ____
Phone / Email: ____

7. Preferred reimbursement method for this and all future claims.

You need only make a selection the first time you submit a claim.

- o Check
- o Direct Deposit (please fill out information below)
  - Name of Bank:____
  - Account Type (Checking or Savings)______________________________
  - Routing Number: ____
  - Account Number:____

8. Checklist.

Before submitting this form, did you...

1. Include proof of payment for all claims being submitted, including doctor's prescription for over-the-counter medications?
2. Sign and certify the Form in Section 5?
3. Full complete each column in Section 3?
4. Check the available balance in your Money Market fund within your Emeriti Health Account, and transfer funds, if necessary, to cover the cost of reimbursement?
5. Retain a copy of this Form and all supporting documentation in the event that your claim requires additional information for processing?
6. Include all pages of the QME form with your submission?

9. Submission of Materials.

Your Claim Form and supporting documents can be submitted by either fax, mail or online.

Fax	Mail	Online
215-563-9943	**Savitz** **Attention: Emeriti Benefits Center** **14th Floor** **1845 Walnut Street** **Philadelphia, PA 19103**	**MyEmeritiBenefits.org** Personalized benefits website. View insurance information, check status of reimbursements, and electronically submit QME claims

For more information about what qualifies as a reimbursable out-of-pocket medical expense, please visit:
http://www.emeritihealth.org/wp-content/uploads/2016/02/IRS-213-EXPENSES.pdf