BURBANK EMPLOYEES RETIREE MEDICAL TRUST

Administered By: Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906 Telephone
(888) 806-8944 (213) 406-2350 Facsimile (562) 463-5894

MEDICAL EXPENSE REIMBURSEMENT CLA1M FORM

Retiree Name:_____

Street Address:_____

City/State/Zip: _____

Telephone Number: _____

If Claim by Beneficiary, complete for Beneficiary:

Name: _____

Address: _____

Instructions to submit claims for reimbursement:

1. Reimbursements will be made directly to the participant or eligible beneficiary; they cannot be assigned to the provider. Claims are processed monthly.
2. Please submit expenses covered by other medical and/or dental plans to those plans first.
3. You must attach detailed itemized verification for each expense or service. Verification should contain (1) patient (covered individual) name; (2) date the item was purchased, or service was provided; (3) description of expense or service; and (4) out-of-pocket amount.
4. Claims and supporting documentation become the property of the Plan and *cannot be returned to you.* If you wish to keep copies, please make them before you submit the claim.
5. All expenses must be itemized and eligible for reimbursement under the Plan guidelines. (For a definition of "Covered Expenses," please refer to Sec. 1.11 of the Plan.)

Service Date	**Provider For** (Circle one or more)	**Expense Provider**	**Type of Service/Item** (Circle One)	**Amount Requested**	**Administrator Use Only**
	Name:_____ Self Spouse Dependent		Medical Dental Vision Other: _____	$_____.____	
	Name:_____ Self Spouse Dependent		Medical Dental Vision Other:_____	$_____._____	
	Name:_____ Self Spouse Dependent		Medical Dental Vision Other:_____	$_____._____	
			TOTAL REQUESTED	$_____.____	

Service Date: When you or your eligible dependent received the care or service; Provided For: Who received service/item; Expense Provider: Who provided the care, service or coverage; Type of Coverage or Service: Please circle one; Amount Requested: Cannot exceed your actual out-of-pocket expense (i.e., after insurance coverage applies) or either your monthly Personal Benefit Level or Employee Account balance.

READ CAREFULLY:

A. I hereby certify that I am not currently employed by the City of Burbank ("City") and was not employed by the City when the attached expenses were incurred. I understand that my benefits will be suspended until such time as I terminate all City employment. If I return to employment with the City, then I will inform the Trust Office.

B. I affirm (1) the information provided in this claim request is true and correct; (2) the amount of the submitted claim to the Trust Office is an accurate statement of my unreimbursed medical/dental/vision expenses; and (3) the submitted claim has not been reimbursed from any other source.

C. With respect to claims submitted on behalf of eligible family members, I hereby certify that such person meets the Plan requirements and is an eligible Beneficiary as defined under the terms of the Plan. (See Plan Section 1.4)

D. I understand that the Plan may pursue legal and equitable remedies against me for any false, fraudulent, or misleading information provided on this form. I agree to indemnify and reimburse the Trust on demand for overpayment of benefits, and any liabilities or damages incurred, because of a fraudulent claim payment.

E. I certify under penalty of perjury that I have read this Form and all information on this Form is true, accurate and correct to the best of my knowledge.

Type of documentation attached: _____

_____	_____	_____
Participant or Beneficiary Signature	Relationship to Retiree	Date Signed