BURBANK EMPLOYEES
RETIREE MEDICAL TRUST

MONTHLY PREMIUM REIMBURSEMENT CLAIM FORM

Plan Participant Name:_____

Spouse's Name:_____

Address: _____

Date of Retirement or Termination of Employment: _____

Date of Birth: _____ Social Security Number: _____

Daytime Phone #: _____ E-mail Address: _____

1) Reimbursement Limited to Premium Expenses Actually Paid. As a Beneficiary in the Medical Expense Reimbursement Plan (Plan) of the Burbank Employees Retiree Medical Trust (Trust), I understand that I have the option to elect to receive a monthly reimbursement benefit for health insurance premium payments that I make. I understand that the benefits that the Trust pays cannot exceed the amount of the premium expenses actually paid. I have elected to receive reimbursement of health (medical, dental, prescription drug, vision or qualified long-term care) insurance premiums, as stated on page two. I certify that the claim below is for premium expenses incurred on behalf of me or my eligible Beneficiaries. These expenses have not been reimbursed, and I will not seek reimbursement, from any other source.

2) Pre-tax Premiums Not Reimbursable. I understand that insurance premiums paid pre-tax are not reimbursable by this Plan. Payment "pre-tax" means that you paid the premium with income that is not taxable to you, e.g., the premium amount was deducted from your spouse's income prior to taxation. For example, your spouse paid a premium through your spouse's cafeteria plan at his/her job, and that amount of your spouse's salary won't be taxable income to you or your spouse. This also applies to insurance premiums paid to a healthcare plan from my pension plan (e.g., 457 or 401k plan), and claimed as nontaxable income on my personal income tax return pursuant to the HELPS Act.[1] I am not requesting reimbursement of any insurance premiums that were paid pre-tax by an employer or deducted from payroll pre-tax.

3) Documentation of Premiums. I understand that premium reimbursement will not commence until I have: (1) signed this Claim Form and returned it to the Trust Office; (2) provided written documentation from the insurance carrier or another third-party verifying the type of insurance coverage, effective date, and premium amount; and (3) submitted proof of my payment of the premiums. I understand that at least once a year I will be required to furnish a new Claim Form and new third-party documentation of my insurance coverage. I also understand that I must submit proof of my payment of each monthly premium for which I request reimbursement. I understand that I can submit the proof of payment of premiums monthly or in batches, but proof of payment must be submitted before a claim for reimbursement will be paid.

4) Change in Premiums. I agree to notify the Trust within 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. I understand that I will need to submit a new claim form and third-party documentation of my insurance coverage, if my premiums change during the year.

[1] Healthcare Enhancement for Local Public Safety Officers (HELPS) Act. See page 6 of IRS Publication 575.

I am enrolled in the following health insurance plan(s) with the following premiums:

☐ Medical: _____

Monthly Premium: $_____ Effective Date: _____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Dental: _____

Monthly Premium: $_____ Effective Date: _____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Vision: _____

Monthly Premium: $_____ Effective Date: _____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Drug: _____

Monthly Premium: $_____ Effective Date: _____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

☐ Other: _____

Monthly Premium: $_____ Effective Date: _____ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

Total Monthly Premium Reimbursement Requested $ _____

5) Income Tax Deductions Prohibited. I understand that these benefit payments are not taxable, and therefore, the premium amount reimbursed is not allowed as a deduction when filing my individual income tax return. I understand that I am responsible for any income tax penalties incurred related to improper deduction of insurance premiums reimbursed pursuant to this claim.

6) Premium Payment to Insurance Carrier. 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.

7) Claims Limited to Covered Expenses. If I request and receive reimbursement from the Trust for an expense that does not qualify for reimbursement under this Plan (see Plan Section 1.11, "Covered Expense"), or that does not have sufficient documentation, I understand that the Trust may pursue recoupment of overpaid benefits or penalties for failure to withhold taxes, including offsetting future benefits.

8) Fraudulent Claims. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided, e.g. failure to advise the Trust of termination of coverage or change in premium.

9) **Suspension of Benefits During Re-employment with the City of Burbank**. I affirm that I am not currently employed by the City of Burbank (including part-time or contract work) and was not employed by the City when the claimed expenses were incurred. I affirm that I do not intend to start employment with the City within the next year, and if I do, I will inform the Trust Office prior to my first day of work.

I certify under penalty of perjury that the information I have given above is true and correct, and that I have read and understood the information included in this Claim Form.

_____ _____

Eligible Retiree or Surviving Spouse/Child Signature Date

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