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 CLAIM FORM

Retiree Name: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Phone: ____________________
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. Each submission must have corresponding documentation such as an EOB or a receipt for a co-pay or bills showing amount and nature of expense, period of time or date incurred covered by the bill and the address or Tax ID of the service provider.
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 then before you submit the claim.
5. All expenses must be itemized and allowable under the Plan guidelines. (For a definition of "Covered Expenses," please refer to Sec. 1.0 of the Plan.)

Service Date	**Provided *For*** (Circle one or more)	Expense **Provider**	**Type of Service/Coverage** (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; Premium Period: Month(s) covered by Premium payment; Provided For: Who received service; Provider/Carrier: Who provided the care, service or coverage; Type of Coverage or Service: Please circle one; Amount Requested: Cannot exceed your out-of-pocket expense after insurance payment.

I certify that the above claim(s) submitted for reimbursement by me to the Medical Expense Reimbursement Plan was incurred for services or premiums on behalf of me or my eligible dependents and, have not been paid by another health plan. I understand that expenses reimbursed through this Plan are not allowed as deductions or credits when filing my individual income tax return.

Type of documentation attached: ____________________

____________________ Participant or Beneficiary Signature

____________________ Relationship to Retiree

____________________ Date Signed