Emeriti Retirement Health Solutions
Qualified Medical Expense Claim Form

The Emeriti Reimbursement Benefit

This form is used to submit claims for Qualified Medical Expenses (QME), otherwise known as the Emeriti Reimbursement Benefit, 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. Prepaid premiums, up to 12 months in advance, may be reimbursed; in such cases, you must submit an insurance statement that defines what your contracted premium amount is for the year or for the defined coverage period for which you are requesting reimbursement with this form. 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 Account (HSA) or Flexible Spending Account (FSA) upon termination of employment 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 obtain reimbursement of a QME incurred by you or your dependents, or for additional information regarding the Plan, please refer to the Summary Plan Description. Please review your Summary Plan Description prior to submission for the list of qualifying dependents under your employer's Plan.
- 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 8 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:	**OR**	**Mail to:**
1-866-830-1639		**Acclaris** **PO Box 25171** **Lehigh Valley, PA 18002**

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: an itemized 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 prescribed over-the-counter medicines and drugs purchased on or after January 1, 2011, reimbursement requests must also include a copy of the doctor's prescription (or a printed Rx number on the health expense receipt) in addition to the other requested information outlined in the table below:

Date(s) of Service	**Service Provider** (Name of Clinic, Doctor, Pharmacy, Store, etc.)	**Description of Expense** (Ex.: Long Term Care Premium, RX 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

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 permitted under my Plan) and that the description of these expenses is accurate and satisfies the guidelines specified under Section 9003 of the Patient Protection and Affordable Care Act, Internal Revenue Code Section 213(d), and supporting IRS Regulations. I certify that any prescribed 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) medical care, as defined in Internal Revenue Code Section 213(d), 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 understand and certify that if I (or my eligible surviving dependents) receive a refund of a reimbursed premium from any medical provider or insurance company, I am obligated to return the reimbursed premium amount to my Emeriti account. 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, Emeriti Retirement Health Plan Solutions, its officers and employees, and my institution's Plan harmless for payment of any ineligible expenses presented in such a manner.

Signature: X ____________________ 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?
- ☐ include a copy of the doctor's prescription (or a printed Rx number on the health expense receipt) for over-the-counter medicines and drugs purchased after January 1, 2011?