



VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN BENEFITS REIMBURSEMENT REQUEST FORM - Page 1 of 2

- Complete this form and send with supporting documentation to **VantageCare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611** or fax to 888-665-8495 for processing. Alternatively, you may submit reimbursements and documentation online via Account Access (www.icmarc.org/login). Select your RHS plan and then Claims to get to the Meritain Health claims portal.
- For privacy and security reasons, ICMA-RC removed Social Security Number as an identifier on this form. Please provide your ICMA-RC Reference Code instead of your Social Security Number. If you do not know your Reference Code, it is available through Account Access on the My Profile tab and on your ICMA-RC statements.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, amount charged, insurance payments, as well as the name of the claimant. **Supporting documentation may consist of: Itemized Bills, Explanation of Benefits, Premium Notices, Itemized Receipts.**
- Eligible claim expense(s) for reimbursement must be incurred on or after your eligibility date. Generally, claims should be submitted within two years from the date of the expense, but this limit may vary among plans. If you have questions regarding this limit or your claims, please contact Meritain at 888-587-9441.

PLEASE NOTE: SIGNATURE IS REQUIRED FOR PROCESSING. Do **not** submit claims for charges eligible under your insurance or Medicare. A medical care expense may not be reimbursed from a Flexible Spending Account (FSA) if the expense has been reimbursed or is reimbursable under any other accident or health plan. If a medical care expense is eligible for coverage by both a Health Reimbursement Arrangement (HRA) and a health FSA, amounts available under a HRA must be exhausted before reimbursement may be made from a health FSA. This requirement does not apply to medical care expenses which are reimbursed from a health FSA but are not reimbursable by a HRA. In no case may a participant be reimbursed for the same medical care expense by both a HRA and a health FSA. Do **not** submit claims for services provided prior to your benefit eligibility date. Claims are processed upon receipt of documents in good order.

If you are able to access funds from your RHS plan in the same year in which you contribute to your Health Savings Account (HSA) administered through another provider, please consult your tax advisor prior to submitting reimbursement to your RHS account. There are specific rules governing HSAs when an employee is also enrolled in a HRA, like the RHS plan, that may affect the tax treatment of the HSA contributions.

Part A: Plan and Participant Information

Employer Plan Number 8 0 0 1 1 5	Employer Name CITY OF GLENDALE	State CA
Participant Name (Last, First, and Middle Initial) _____	Address _____	
Reference Code _____	STREET _____	
Daytime Phone Number (_____) _____ - _____	CITY _____ STATE _____ ZIP _____	
<i>NOTE: If this is a new address, please contact ICMA-RC at 800-669-7400 to update your address. Your check will be mailed to the address on file with ICMA-RC.</i>		

Part B: Request for Reimbursement of Non-Recurring Expenses

Use this section to request a reimbursement of non-recurring expenses (e.g., co-payments, medications, out-of-pocket expenses).

Summary of Healthcare Expenses

Incurred Date*	Applicant's Full Name (last, first, middle initial)	Provider (e.g. doctor name/pharmacy name)	Claim for (self, spouse, dependent child, other dependent)	Description of Service	Amount to be Reimbursed
					\$
					\$
					\$
Total reimbursement request:					\$

* Incurred date is the date of service, not the billing or payment date.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature _____

Date _____



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BENEFITS REIMBURSEMENT REQUEST FORM - Page 2 of 2**

Participant Name (Last, First, and Middle Initial)

Reference Code

Part B: Request for Reimbursement of Recurring Expenses

Use this section to request automated reimbursement of recurring expenses (e.g. insurance premiums). **Note:** Payment must be made to the account holder. Payment will **not** be made directly to an insurance company or other third party.

You are responsible for ensuring automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Supporting documentation must show the premium is paid with after-tax funds and include the following: (i) Insurance Carrier; (ii) Type of Insurance; (iii) Policy Holder's Name; (iv) Amount; and (v) Coverage Period. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

1. **BEGIN** recurring reimbursement of \$ _____

Beginning Date: Insert date you wish payments to begin ____ / ____ / ____ (MM/DD/YYYY)

Frequency (Check one): Annual Quarterly Monthly

Ending Date: Insert date of last payment ____ / ____ / ____ (MM/DD/YYYY)

2. **CHANGE** recurring payment amount from \$ _____ to \$ _____

Effective date of change 06 / 01 / 2020 (MM/DD/YYYY)

3. **END** recurring payment of \$ _____

Ending Date: Insert date of last payment ____ / ____ / ____ (MM/DD/YYYY)

Note: Payments will continue until your account is depleted, unless an ending date is provided. Any changes to your payment must be received by Meritain Health at least 10 business days prior to next payment. Otherwise the change will take effect on the next scheduled reimbursement.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes, including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature

Date

PLEASE RETAIN A COPY FOR YOUR RECORDS

Send completed form to: VantageCare Retirement Health Savings (RHS) Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611 • 888-587-9441

FRM080-002-0516-8355-C1333

REV 5/2018



CITY OF GLENDALE, CALIFORNIA

Human Resources
Civil Service Commission

613 E. Broadway, Suite 100
Glendale, CA 91206-4308
Tel. (818) 548-2110
glendaleca.gov

INSTRUCTIONS

Change Premium Automatic Reimbursement with ICMA - RHSP

To make a change to an automatic reimbursement for your insurance premiums with ICMA you will need to submit the following form:

- **VantageCare Retirement Health Savings (RHS) Plan Benefits Reimbursement Request Form**

Complete the Vantage Retirement Health Savings (RHS) Plan Benefits Reimbursement Request Form.



VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN BENEFITS REIMBURSEMENT REQUEST FORM

Part A: Plan and Participant Information

Part A: Plan and Participant Information			
A	Employer Plan Number 8 0 0 1 1 5	Employer Name City of Glendale	State CA
	Participant Name (Last, First, and Middle Initial) RETIREE'S NAME	Address RETIREE'S HOME ADDRESS	
D	Reference Code	STREET	

- Employer Plan Number** – your plan number is **800115**. The number can also be found on your ICMA statements.
- Employer Name** – City of Glendale
- Retiree's Information** - The rest of the section needs to be filled in with the retiree's personal information.
- Reference Code** – This can be found on your ICMA statements.

Part B (side 2 or page 2): Request for Reimbursement of Recurring Expenses

Part B: Request for Reimbursement of Recurring Expenses

Use this section to request automated reimbursement of recurring expenses (e.g., insurance premiums). **Note:** Payment must be made to the account holder. Payment will **not** be made directly to an insurance company or other third party.

You are responsible for ensuring that automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring that automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Supporting documentation must show that the premium is paid after taxes and include the following: (i) Insurance Carrier; (ii) Type of Insurance; (iii) Policy Holder's Name; (iv) Amount; and (v) Coverage Period. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

1. **BEGIN** recurring reimbursement of \$ _____
 Beginning Date: Insert date you wish payments to begin ____ / ____ / ____ (mm/dd/yyyy)
 Frequency (C): Annual Quarterly Monthly
 Ending Date: **A** te of last payment ____ / ____ / ____ (mm/dd/yyyy)

2. **CHANGE** recurring payment amount from \$ **CURRENT PREMIUM AMOUNT** to \$ **NEW PREMIUM AMOUNT** **B**
 Effective date of change **06** / **01** / **2014** (mm/dd/yyyy)

3. **END** recurring payment of \$ _____
 Ending Date: Insert date of last payment ____ / ____ / ____ (mm/dd/yyyy) **C**

2. CHANGE – this section is to be used to change recurring payments.

- Enter your current total premiums you are receiving for reimbursement.
- Enter your new total premium amounts for reimbursement.
- Enter 06/01/20xx for the effective date of the new premium amounts.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned certifies that, under the American Recovery and Reinvestment Act (ARRA) he/she may not receive reimbursement of federally subsidized COBRA premiums through a Health Reimbursement Arrangement (HRA) such as the VantageCare Retirement Health Savings (RHS) plan. The undersigned certifies that he/she is not submitting such subsidized premiums for reimbursement.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands that he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands that he/she will be liable for payment of all related taxes including Federal, state or local income tax on amounts paid from the Plan for non-qualifying expenses.

Participant Signature

Date

- Please be sure to sign the form
- Include all requested supporting documentation. The supporting document will be your June 1st billing statement from PayFlex.

Submitting the form to VantageCare RHS Plan

- You can fax the form with a copy of your **June's PayFlex Bill** at (888) 665-8495
- Mail: VantageCare RHS Plan, c/o Meritain Health, Inc. PO Box 30136, Lansing, MI 48909-7611
- Questions Call: Reimbursement Inquires: Meritain at (888) 587-9441 or Balance Inquires: VantageCare RHS at (800) 669-7400