MANHATTAN BEACH POLICE OFFICER'S ASSOCIATION
RETIREE MEDICAL REIMBURSEMENT PLAN

CLAIM FORM

Retiree Participant Name: _____ _____ _____
First Last DOB
Home Address: _____ City: _____ State: _____ Telephone: _____

Claim is for: Self Spouse: _____ Dependent: _____
(Circle) Name Name

HEALTH CARE EXPENSES: Supporting documents must accompany this claim form. Provide the Explanation of Benefits Form (EOB) if another health provider paid any portion of this claim.

Medical or Dental Insurance Premium: _____ Reimbursement Expense: $_____
(Out of Pocket Expense) Health Provider

HMO Co-Pay Expenses: _____ Reimbursement Expense: $_____
(Submit Paid Receipt Showing Co-Pay) Health Provider

I have group health insurance for this expense, but it is not fully covered and I have out of pocket expenses. (Attach EOB form). Reimbursement Expense: $_____

I do Not have coverage for this expense. (Attach itemized statement showing the date of service, provider's name, service provided, and paid receipt). Reimbursement Expense: $_____

Other Health Expenses: I am submitting receipts for approved health care expenses for over the counter drugs for personal use to alleviate or treat personal injuries or sickness (Submit receipt that includes the name of the store, date of purchase, the price and name of the item). Reimbursement Expense: $_____

Dental Expenses: _____ Reimbursement Expense: $_____
(Out of Pocket Expenses, Attach Explanation of Benefits)

Total Reimbursement Expenses Submitted: $_____

READ CAREFULLY:

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Manhattan Beach Police Officer's Retiree Medical Reimbursement Plan and Trust, with respect to such expenses and that the health care expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Retiree Participant Signature **Date**

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Please send claims to:

Flex-Care
Keenan Health Care
P.O. Box 2744
Torrance, Ca. 90509

Claims: (310) 781-8270 ext.3233
Phone: (800) 653-3626
Fax: (310) 212-3381