Post Retirement Medical Allowance Claim Form

EMPLOYEE INFORMATION

Name: _____ Last four digits of your Social Security #: __ __ __ __

Address: _____ Company Name: _____

City/State/Zip: _____ DOB: _____

Email Address: _____

☐ **Please check box if information has changed.**

***EXPLANATION OF BENEFITS (EOB) MUST ACCOMPANY ALL CLAIM FORMS FOR OUT-OF-POCKET EXPENSES**

Not Eligible for Medicare Retirement Account Benefits

Patient's Name:	DOB	Type of Services Select one box below for each expense type: MD= Medical, Rx=Prescription, DN=Dental, VS=Vision, PREM=Premium	Date(s) of Service: mm/dd/yyyy		Amount of Charge:
		☐ MD ☐ Rx ☐ DN ☐ VS ☐ PREM	From:	To:	
		☐ MD ☐ Rx ☐ DN ☐ VS ☐ PREM	From:	To:	
		☐ MD ☐ Rx ☐ DN ☐ VS ☐ PREM	From:	To:	
		☐ MD ☐ Rx ☐ DN ☐ VS ☐ PREM	From:	To:	
			Total Amount Requested:		

***EXPLANATION OF BENEFITS (EOB) MUST ACCOMPANY ALL CLAIM FORMS FOR OUT-OF-POCKET EXPENSES**

Medicare Eligible Retirement Account Benefits

Patient's Name:	DOB	Type of Services Select one box below for each expense type: MD= Medical, DN=Dental, VS=Vision, PREM=Premium	Date(s) of Service: mm/dd/yyyy		Amount of Charge:
		☐ MD ☐ DN ☐ VS ☐ PREM	From:	To:	
		☐ MD ☐ DN ☐ VS ☐ PREM	From:	To:	
		☐ MD ☐ DN ☐ VS ☐ PREM	From:	To:	
		☐ MD ☐ DN ☐ VS ☐ PREM	From:	To:	
			Total Amount Requested:		

Please arrange documentation in order listed above.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed were incurred during the current period under the company's Retirement Account. The undersigned participant in the Plan understands that expenses are "incurred" when a service is performed or care is provided, not when the bill is paid. The undersigned certifies that all expenses for which reimbursement or payment is claimed on this form were incurred on the dates of service stated above. The undersigned fully understands that he or she is alone fully responsible for the sufficiency, accuracy, and veracity of all the information relating to this claim and 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.

_____ _____

Employee's Signature (must be signed for proper processing) Date

To Submit a Claim:

- Send your claim form along with all supporting documentation directly to BeneFLEX via email: info@beneflexhr.com, fax: 314.909.6983, or mail: 10805 Sunset Office Drive., Ste. 401, St. Louis, MO 63127.

Claims Processing Deadline:

- **Tuesday at 3:00 p.m. CST; 4:00 p.m. EST. BeneFLEX issues checks on Thursday.**