SDCERS
San Diego City Employees' Retirement System

Health Insurance Reimbursement Form
Annual Plans

For City Retirees Enrolled in Non-City Sponsored Health Plans

Member Name Middle Initial Last Name SDCERS ID	
Medical Plan Name:	Coverage Start Date: Coverage End Date:
Are you the policy holder or the dependent? Policy Holder [ ] Dependent [ ]	Level of Coverage: Single [ ] 2-Party [ ] Family [ ] Number of Enrollees on Family Plan ___
Total Monthly Premium Amount: $ Monthly Premium Amount for Member Only: $	Does this amount include a discount, tax credit or subsidy*? Yes [ ] No [ ] If yes, what is the amount of the discount, tax credit or subsidy? $ ***Note: Due to premium fluctuations associated with the Advanced Premium Tax Credit, enrollees receiving the APTC must submit proof of premium/payment monthly and cannot use this form**

In order to be reimbursed, I have attached the following documentation:

Proof of Premium Amount and Plan Coverage (Premium information must include details of premium costs for ***each*** subscriber on the plan.)

- Rate chart from the insurance company or employer; or
- Signed letter from the insurance company stating your name, amount of premium and the effective date of coverage.

Proof of Initial Payment

- Pay stub with deduction clearly noted; or
- Bank or credit card statement AND corresponding invoice; or
- Cancelled check (must provide both sides) AND corresponding invoice; or
- Cashier's check or money order, AND corresponding invoice; or
- Signed letter or receipt from insurance company AND corresponding invoice

Acknowledgment and Declaration

I have read and understand this form. I certify, under penalty of perjury, that the information provided is correct. I certify that the expenses listed qualify for reimbursement under the Internal Revenue Code §213(d) and they have not or will not be reimbursed from any other plan. I further certify that I will not claim these expenses as an income tax deduction and that these premiums have not been, and are not eligible to be, deducted on a pre-tax basis through an Internal Revenue Code §125 cafeteria plan. I assume all liability for taxes and penalties that may be assessed for any disallowed deductions/credits.

I acknowledge that the monthly reimbursement will continue for up to 12 months, or until the plan(s) or premium(s) cease or change, whichever occurs first. The coverage I have indicated above is currently in effect and I agree to notify SDCERS immediately if my plan(s) or premium(s) cease or change. I understand that my reimbursement history is subject to audit. If I receive a reimbursement in excess of the actual cost of my coverage, I agree to repay the full overpayment and accept repayment terms determined by the City of San Diego. If you had a change in premium and are owed additional reimbursement, the adjustment will be made and added to your monthly pension payment. **Retirees are required to retain supporting documentation for three (3) years for audit purposes.**

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RETIREE/BENEFICIARY SIGNATURE **DATE**

Email, mail or fax to:

Email: health@sdcers.org (for email, read important security note below)
Mail: SDCERS, Attn. Health Reimbursements, 401 West A Street, Suite 800, San Diego, CA 92101
Fax: 858-581-5314

Email Disclaimer: Be advised that sending private information regarding your health insurance and health treatment via email is at your own risk and SDCERS cannot guarantee the security of the information you transmit over the Internet. Once received by SDCERS, internal procedures provide proper security and confidentiality of all member information received. For more information and instructions for sending files via email, see the disclaimer on Health Forms and Booklets page at www.sdcers.org.