SDCERS
San Diego City Employees' Retirement System

City of San Diego COBRA Insurance Reimbursement

For City Retirees Making Payments to WageWorks

First-Time Request (Requesting a reimbursement for the 1st time) ❑	**Change Request** (Changing your health plan or premium amount) ❑

Member Name	Middle Initial	Last Name
Street Address		
City	State	Zip
Phone	Last 4 Digits of Social Security Number	

If you are making payments to Benefit Services or private COBRA plan, use the *Health Insurance Reimbursement* form.

Please see the section of the Open Enrollment book that pertains to your retirement date to determine health allowance and what types of expenses qualify for reimbursement. This varies depending on your retirement date.

PLAN PREMIUM INFORMATION

SDCERS requires that you provide the total out-of-pocket cost for <u>your portion only</u> of your health premium that you pay, in order for you to be reimbursed. Please provide the following information and attach the required documents, detailing the breakdown of your plan premium costs, explained on the back of this form.

Medical Plan Name		
Are you the policy holder or the dependent? Policy Holder ❑ Dependent ❑	Effective Date of Coverage/Change	Total number of people covered by this plan (including yourself) _____
Is 100% of the premium paid by you? Yes ❑ No ❑	If No, please explain:	
Monthly out-of-pocket cost for SDCERS Member's or Beneficiary's Coverage* (Do not include cost for others covered by this plan) $_____		

IMPORTANT: If your coverage or plan premium changes at any time (typically at the beginning of the plan year), you must notify SDCERS by completing a new *COBRA Insurance Reimbursement* form and attaching all required documentation.

DOCUMENTATION (PROOF OF PLAN PREMIUM, PROOF OF COVERAGE, PROOF OF PAYMENT)

IMPORTANT: Any form sent without supporting documentation will not be processed.

❑ Initial proof of plan coverage and premium amount—

- Full page copy of WageWorks invoice

❑ Initial Proof of Payment—Examples include:

- Receipt from WageWorks
- Bank or credit card statement
- Canceled check (must provide both sides)
- Cashier's check or money order

To ensure timely payment in any given month, documents providing proof for reimbursement must be received no later than the 10th of the month. Documentation received after the 10th of the month will be processed the following month. Reimbursement requests for expenses incurred more than 12 months prior to the request date will not be reimbursed.

RETIREE/BENEFICIARY SIGNATURE

I have read and understand this form. I understand that any reimbursement made to me by SDCERS will not be reported to the Internal Revenue Service (IRS) on Form 1099-R as taxable income. If the IRS requires any tax payment from the health insurance reimbursement I receive, I understand that I am responsible for all taxes.

I agree to notify SDCERS immediately if my plan or premium(s) cease or change. If I receive a reimbursement overpayment, I agree to repay the full overpayment and accept repayment terms determined by SDCERS.

RETIREE/BENEFICIARY SIGNATURE _____ DATE _____

Email, mail or fax to:

Email: health@sdcers.org as a PDF (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 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.