SDCERS
San Diego City Employees' Retirement System

Health Insurance Reimbursement

For City Retirees Enrolled in Non-City Sponsored Health Plans

Member Name	Middle Initial	Last Name	SDCERS ID

PLAN PREMIUM INFORMATION

SDCERS requires that you provide the total out-of-pocket cost for your portion only of the health premium. Please provide the following information and attach the required documents, detailing the breakdown of your plan premium costs.

Medical Plan Name		
Are you the policy holder or the dependent? Policy Holder ❑ Dependent ❑	Effective Date of Coverage	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 costs for SDCERS Member's or Beneficiary's Coverage (Do not include cost for others covered by this plan) $____________		

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

Proof of Premium Amount and Plan Coverage

- Submit a rate chart from the insurance company or employer
- Submit a signed letter from the insurance company stating your name, amount of premium and the effective date of coverage. Must include all details of your premium rates separately from dependent costs, if dependent costs exist.

Proof of Payment On a Monthly or Quarterly Basis

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

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.

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 (for email, read important security note below)
Mail: SDCERS, Attn. Health Reimbursements, 401 West A Street, Suite 400, 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.