

CITY OF LOS ANGELES
DEPARTMENT OF FIRE AND POLICE PENSIONS
 360 East 2ND Street, Suite 400, Los Angeles, CA 90012
 T: (800) 787-2489, EXT. 84560 or (213) 978-4560
 F: (213) 978-4504 (ATTN: Medical & Dental Benefits)
<http://www.lafpp.com/LAFPP/retired.html>

**RETIRED HEALTH INSURANCE
 PREMIUM REIMBURSEMENT
 CLAIM FORM**

IMPORTANT DATES

✓ COVERAGE PERIOD WITHIN	CLAIM FORM MUST BE RECEIVED BY	REIMBURSEMENT SENT ON
<input type="checkbox"/> JANUARY 1 – MARCH 31 <input type="checkbox"/> APRIL 1 – JUNE 30 <input type="checkbox"/> JULY 1 – SEPTEMBER 30 <input type="checkbox"/> OCTOBER 1 – DECEMBER 31	NO LATER THAN: APRIL 15 JULY 15 OCTOBER 15 JANUARY 15	MAY 31 AUGUST 31 NOVEMBER 30 FEBRUARY 28

SECTION A: APPLICANT INFORMATION

LAST NAME:	FIRST NAME, MIDDLE INITIAL:	SOCIAL SECURITY NUMBER: XXX-XX-
ADDRESS: (Must be the same as on file with this Department)		8:00 AM THRU 5:00 PM TELEPHONE NUMBER:
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	MEDICARE COVERAGE: PLEASE CHECK ONE: PARTS A & B ____ PART B ONLY ____ NOT ELIGIBLE ____ PLEASE PROVIDE A COPY OF YOUR MEDICARE CARDS IF YOU HAVE NOT DONE SO BEFORE.	

SECTION B: HEALTH INSURANCE COVERAGE

COVERAGE FOR (NAME / RELATIONSHIP)	COVERAGE BY (COMPANY NAME)	MEDICAL RECORD NUMBER OR ID NUMBER	COVERAGE MONTH (S)	MONTHLY PREMIUM	TOTAL PAID
SELF / PENSIONER (MUST BE THE PRIMARY MEMBER IN THE PLAN)					
MEDICARE PART D:					

PLEASE DO NOT ADD MEDICARE PART B PREMIUM PAYMENTS ON THIS FORM. IF APPLICABLE, IT WILL BE ADDED TO YOUR HEALTH INSURANCE PREMIUM REIMBURSEMENT EACH CLAIM PERIOD.

TOTAL:

NOTE: CLAIMS WITHOUT PROPER DOCUMENTATION VERIFYING HEALTH COVERAGE AND PAYMENT(S) WILL NOT BE PROCESSED.

Does another pension/retirement plan or your current employer pay for a portion of the monthly premium? Yes ____ No ____

If yes, what amount of the monthly premium do they pay? \$ _____

SECTION C: APPLICANT VERIFICATION

I CERTIFY THAT THE HEALTH COVERAGE LISTED WAS PROVIDED FOR MYSELF AND QUALIFIED DEPENDENTS DURING THE PERIOD INDICATED. I FURTHER CERTIFY THAT ALL INFORMATION AND DOCUMENTATION PROVIDED ARE TRUE AND ACCURATE. I UNDERSTAND THAT THE DEPARTMENT MUST BE IMMEDIATELY INFORMED OF CHANGES IN OR CANCELLATION OF COVERAGE. I UNDERSTAND THAT ANY FALSE, DECEPTIVE OR OTHERWISE IMPROPER ACT MAY RESULT IN THE SUSPENSION OF MY PARTICIPATION IN THE HEALTH INSURANCE REIMBURSEMENT PROGRAM FOR THREE YEARS AND THE RECOVERY OF AMOUNT PAID FALSELY.

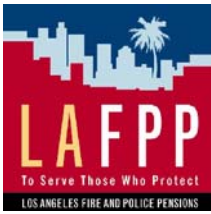
Signature: _____ Date: _____

Email Address (if any): _____

SIGN, DATE AND SUBMIT AFTER THE COVERAGE PERIOD HAS ENDED.

FOR OFFICE USE ONLY

FUND	YOS	MAX. SUBSIDY	MC VERIFIED	HR TOTAL	MR ADDED AMT	MANAGEMENT APPROVAL
						INITIALS: DATE:
ADDRESS	PHONE	PROOF OF PAYMENT		HEALTH INSURANCE CARD	MEDICARE CARD	



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 PREMIUM REIMBURSEMENT
 CLAIM FORM

INSTRUCTIONS FOR SUBMITTING A CLAIM

FILL IN EACH SECTION COMPLETELY

- SECTION A: APPLICANT INFORMATION:** If applicable, you must provide a photocopy of your Medicare Card the first time you file a claim and upon request thereafter. Your address on the HIPR claim form must be the same address as on file with the Department.
- SECTION B: HEALTH INSURANCE COVERAGE INFORMATION:** Attach a copy of your health insurance card, Medicare card, and Part D Supplemental Plan card (only if this is your first time submitting a claim or if any part of your health insurance coverage has changed) and proof of payment documentation (such as bank statements, copies of cancelled checks, pay stubs, or verification letter from health provider). Payment documentation must reference pensioner's name and/or account number. All documents become part of this claim and will not be returned to you. Please make copies for your records. Qualified Surviving Spouses or Domestic Partners must provide a breakdown of the healthcare costs showing the cost of the coverage if they are enrolled in a two party or family plan since reimbursement is inapplicable to any dependents covered on the plan.
- SECTION C: APPLICANT VERIFICATION:** Sign and date where indicated.

IMPORTANT DATES

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<input type="checkbox"/> APRIL 1 – JUNE 30		AUGUST 31
<input type="checkbox"/> JULY 1 – SEPTEMBER 30		NOVEMBER 30
<input type="checkbox"/> OCTOBER 1 – DECEMBER 31		FEBRUARY 28

CLAIM FORMS WILL ONLY BE ACCEPTED AFTER THE COVERAGE PERIOD HAS ENDED.

IMPORTANT INFORMATION

- Reimbursements are limited to premiums paid for medical & Medicare Part D coverage; premiums paid for other forms of coverage, such as dental, vision, life, and long-term care will not be reimbursed.
- If claim forms are incomplete or if insufficient documentation is provided, we will contact you for further action. This may delay the processing of your reimbursement. Additionally, there is a chance that your claim form may be postponed until the next processing period. To ensure that your reimbursement is paid out as scheduled, please be sure that all requirements have been met prior to submission.
- Retroactive submissions may be accepted *up to one year* prior from the first month of the current coverage period. Such submissions require a separate claim form for each coverage period that reimbursement is requested. Each claim form must be signed and dated to be processed.
- If you move back to California within a City approved HMO health plan service area, you must notify us immediately at the number below.

If you have any further questions, please contact the Medical and Dental Benefits Section of the Department of Fire and Police Pensions at (800) 787-2489, EXT. 84560 OR (213) 978-4560, and we will be happy to assist you.