Los Angeles Fire & Police Pensions
TO SERVE THOSE WHO PROTECT

RETIRED HEALTH INSURANCE PREMIUM REIMBURSEMENT CLAIM FORM

IMPORTANT DATES		
✓ COVERAGE PERIOD WITHIN	FILING DEADLINE – CLAIM FORMS RECEIVED BY	REIMBURSEMENT SENT ON
☐ JANUARY 1 – MARCH 31	NO LATER THAN: APRIL 15	MAY 31
☐ APRIL 1 – JUNE 30	JULY 15	AUGUST 31
☐ JULY 1 – SEPTEMBER 30	OCTOBER 15	NOVEMBER 30
☐ OCTOBER 1 – DECEMBER 31	JANUARY 15	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 - 5:00 PM TELEPHONE NUMBER:	
CITY:		STATE:	ZIP CODE:

DATE OF BIRTH:

PLEASE CHECK ONE: **HEALTH PLAN COVERAGE**: 1-PARTY PLAN ☐ 2-PARTY PLAN ☐ FAMILY PLAN ☐

PLEASE CHECK ONE: **MEDICARE COVERAGE**: 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 OR ID NUMBER	COVERAGE MONTH(S)	MONTHLY PREMIUM	TOTAL PAID
SELF / PENSIONER					
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 LOS ANGELES FIRE & POLICE PENSIONS (LAFPP) MUST BE IMMEDIATELY INFORMED OF CHANGES IN OR CANCELLATION OF COVERAGE.

I AGREE TO INFORM LAFPP OF ANY HEALTH PLAN PREMIUM REBATE THAT I RECEIVE FOR WHICH I HAVE BEEN REIMBURSED BY LAFFP THROUGH THE HEALTH INSURANCE PREMIUM REIMBURSEMENT (HIPR) PROGRAM AND AGREE TO SUBMIT WRITTEN DOCUMENTATION OF THE REBATE TO LAFPP BY THE FILING DEADLINE OF THE QUARTER THAT FOLLOWS RECEIPT OF THE REBATE. [FILING DEADLINES ARE POSTED AT http://www.lafpp.com/LAFPP/plan_health_sub_program.html]. I AGREE TO REPAY LAFPP THE AMOUNT OF THE REBATE LESS ANY PORTION OF THE PREMIUM PAID THAT HAS NOT BEEN REIMBURSED BY LAFPP AND THAT THE REPAYMENT SHALL BE TENDERED TO LAFPP NO LATER THAN THE END OF THE MONTH BEGINNING AFTER THE AFOREMENTIONED QUARTERLY FILING DEADLINE. I UNDERSTAND THAT REPAYMENT OF THE MEDICAL PLAN PREMIUM MUST BE MADE IN A SINGLE PAYMENT THROUGH PERSONAL CHECK, WITHHOLDING FROM FUTURE HIPR PAYMENTS, OR A DEDUCTION FROM MY PENSION CHECK.

I UNDERSTAND THAT ANY SUBMITTAL OF FALSE OR FRAUDULENT DOCUMENTS AND/OR INFORMATION, INCLUDING THE FAILURE TO DISCLOSE REFUNDS FROM CANCELLED PLANS AND/OR HEALTH PREMIUM PLAN REBATES, AND ANY OTHER 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, PLUS INTEREST IN ACCORDANCE WITH LAFPP BOARD OPERATING POLICY SECTION 3.10.

SIGNATURE: _____ DATE: _____

EMAIL ADDRESS (IF ANY): _____

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

RETIRED HEALTH INSURANCE PREMIUM REIMBURSEMENT CLAIM INSTRUCTIONS

INSTRUCTIONS FOR SUBMITTING A CLAIM

IMPORTANT DATES

✓ COVERAGE PERIOD WITHIN	FILING DEADLINE – CLAIM FORMS RECEIVED BY	REIMBURSEMENT SENT ON
☑ JANUARY 1 – MARCH 31	NO LATER THAN: APRIL 15	MAY 31
☑ APRIL 1 – JUNE 30	JULY 15	AUGUST 31
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- Check the coverage period for the submitted claim.
- Health insurance reimbursements shall be processed and paid on a quarterly basis after the claim form has been submitted. The filing deadline indicates the last day the claim can be received for earliest reimbursement. Claim forms and documentation will be accepted for one year following the claim submission period.
- Claim forms will only be accepted after the coverage period has ended.

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.

OTHER 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.
- Medicare-eligible members enrolled in Parts A and B with covered dependents (spouse or domestic partner and/or children under the age of 26) are eligible to receive up to the maximum non-Medicare subsidy established per the Administrative Code and Charter. Medicare-eligible dependents are required to enroll in Medicare to the fullest extent of their eligibility. Proof of enrollment shall be submitted prior to reimbursement of claims for health insurance premiums.
- 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.

FOR ELIGIBILITY REQUIREMENTS OR QUESTIONS, PLEASE CONTACT OUR OFFICE.

Los Angeles Fire and Police Pensions
Attn: Medical and Dental Benefits Section
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Los Angeles, CA 90013

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(213) 279-3115
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Email: pensions@lafpp.com