VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN BENEFITS REIMBURSEMENT REQUEST FORM - Page 1 of 2

- Complete this form and send with supporting documentation to **VantageCare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611**. You may also fax this request with supporting documentation to 888-665-8495 for processing.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, amount charged, insurance payments, as well as the name of the claimant. ***Supporting documentation may consist of: Itemized Bills, Explanation of Benefits, Premium Notices, Itemized Receipts.***

PLEASE NOTE: *SIGNATURE IS REQUIRED FOR PROCESSING.* Do **not** submit claims for charges eligible under your insurance or Medicare. A medical care expense may not be reimbursed from a FSA if the expense has been reimbursed or is reimbursable under any other accident or health plan. If a medical care expense is eligible for coverage by both an HRA and a health FSA, amounts available under an HRA must be exhausted before reimbursement may be made from a health FSA. This requirement does not apply to medical care expenses which are reimbursed from a health FSA but are not reimbursable by an HRA. In no case may a participant be reimbursed for the same medical care expense by both an HRA and a health FSA. Do **not** submit claims for services provided prior to your benefit eligibility date. Claims are processed upon receipt of documents in good order.

Note to Survivor: Upon the death of the RHS Plan Participant, all claims for decedent's qualified medical expenses should be submitted using the *VantageCare Retirement Health Savings Plan Benefits Reimbursement Request Form*, prior to submitting the *VantageCare Retirement Health Savings Plan Decedent Information Form.*

Part A: Plan and Participant Information

Employer Plan Number ___ ___ ___ ___ ___ ___

Employer Name _____ State _____

Participant Name (Last, First and Middle Initial)

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Daytime Phone Number

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Area Code

Address

Street _____

City _____

State _____ Zip Code _____

NOTE: If this is a new address, please contact ICMA-RC at 800-669-7400 to update your address. Your check will be mailed to the address on file with ICMA-RC.

Part B: Request for Reimbursement of Non-Recurring Expenses

Use this section to request a reimbursement of non-recurring expenses (e.g., co-payments, medications, out-of-pocket expenses).

Summary of Healthcare Expenses

Incurred Date*	Applicant's Full Name (last, first, middle initial)	Provider (e.g. doctor name/ pharmacy name)	Claim for (self, spouse, dependent child, other dependent)	Description of Service	Amount to be Reimbursed

** Incurred date is the date of service, not the billing or payment date.*

Total reimbursement request: $_____

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- Non-prescription medications for which reimbursement is requested were purchased to alleviate or treat personal injuries or sickness.
- The undersigned certifies that, under the American Recovery and Reinvestment Act (ARRA) he/she may not receive reimbursement of federally subsidized COBRA premiums through a Health Reimbursement Arrangement (HRA) such as the Vantagecare Retirement Health Savings (RHS) plan. The undersigned certifies that he/she is not submitting such subsidized premiums for reimbursement.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands that he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands that he/she will be liable for payment of all related taxes including Federal, state or local income tax on amounts paid from the Plan for non-qualifying expenses.

_____ _____

Participant Signature **Date**

PLEASE RETAIN A COPY FOR YOUR RECORDS ***(for recurring expenses see page 2)***

ICMARC
Building Retirement Security

VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
BENEFITS REIMBURSEMENT REQUEST FORM - Page 2 of 2

Participant Name (Last, First and Middle Initial) _____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Part C: Request for Reimbursement of Recurring Expenses

Use this section to request automated reimbursement of recurring expenses (e.g. insurance premiums). Note: Payment must be made to the account holder. Payment will not be made directly to an insurance company or other third party.

You are responsible for ensuring that automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring that automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

1. ☐ **Begin** recurring reimbursement of $_____

   Beginning Date: Insert date you wish payments to begin ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

   Frequency (Check one): ◯ Annual ◯ Quarterly ◉ Monthly

   Ending Date: Insert date of last payment ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

2. ☐ **Change** recurring payment amount from $ _____ to $ _____

   Effective date of change ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

3. ☐ **End** recurring payment of $_____

   Ending Date: Insert date of last payment ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

Note: Payments will continue until your account is depleted, unless an ending date is provided. Any changes to your payment must be received by Meritain Health at least 10 business days prior to next payment. Otherwise the change will take effect on the next scheduled reimbursement.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- Non-prescription medications for which reimbursement is requested were purchased to alleviate or treat personal injuries or sickness.
- The undersigned certifies that, under the American Recovery and Reinvestment Act (ARRA) he/she may not receive reimbursement of federally subsidized COBRA premiums through a Health Reimbursement Arrangement (HRA) such as the Vantagecare Retirement Health Savings (RHS) plan. The undersigned certifies that he/she is not submitting such subsidized premiums for reimbursement.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands that he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands that he/she will be liable for payment of all related taxes including Federal, state or local income tax on amounts paid from the Plan for non-qualifying expenses.

_____ _____

Participant Signature **Date**

PLEASE RETAIN A COPY FOR YOUR RECORDS

Send completed form to: VantageCare Retirement Health Savings (RHS) Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611 • 888-587-9441