EMERITI®
RETIREMENT HEALTH SOLUTIONS

CAPITAL UNIVERSITY

Emeriti Retirement Health Solutions Qualified Medical Expense Claim Form

This form is used to submit claims for Qualified Medical Expenses (QME) under your institution's Emeriti Retiree Health Plan (Plan). Multiple claims submitted together in one envelope are treated as a single submission. Your first four submissions per calendar year are processed free of charge. Each submission thereafter for the rest of the calendar year will incur a $6 charge, assessed to your health account, prior to the claim being paid.

Please review your claim submissions carefully. All claims must be received in good order (with the claim form filled out completely and receipts with all necessary information) to be processed. If the claim is received in good order by Acclaris before the last Saturday of the month, a check will be mailed around the 12th of the following month. Incomplete claims will be returned.

INSTRUCTIONS:

- Use this form to request reimbursement for medical and long-term care expenses, premiums for health insurance not provided by the Plan, premiums for long-term care insurance, or premiums for Medicare. Reimbursement applies to expenses and premiums incurred by you or your eligible dependents that have been designated under the Plan. Expenses must be submitted for reimbursement within 12 months following the end of the calendar year in which the expense was incurred.
- If you need additional space to list your expenses, please attach a separate sheet of paper. Submit all documentation together in order to ensure that the claim is treated as one claim submission.
- Each expense must be accompanied by a receipt or Explanation of Benefits (EOB). Canceled checks or credit card statements are not acceptable receipts.
- Each receipt or EOB must show the Provider's Name, Patient's Name, Date of Service or Purchase, Expense Amount, Service, Treatment, and Medication or Supply Name. For over-the-counter medications or medical supplies, the receipt need only specify the date of purchase and the medication or supply name.
- A single QME claim totaling $100,000 or more must be accompanied by a Signature Guarantee. Signature Guarantees are available from banks, credit unions, and brokerage firms.
- If you have a Health Spending or Flexible Spending Account through the employer sponsoring this Plan, you must exhaust those accounts before requesting reimbursement through this Plan.
- To determine your eligibility to request a QME, or for additional information regarding the Plan, please refer to the Summary Plan Description.
- Checks are mailed to the address on record with Acclaris. If you have questions regarding your address, please call **1-866-EMERITI** (1-866-363-7484), Monday through Friday, 8 a.m. to 9 p.m. Eastern time to update the address or to confirm the address on record prior to submitting this form.
- If you have any questions about your QME claim, call Acclaris toll free at **1-800-317-0559**, Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Fax your form and supporting documentation to the toll-free number, **1-866-830-1639**, or **mail** your completed reimbursement request and copies of supporting documentation to the address below:

Acclaris
PO Box 20571
Tampa, FL 33622-0571

EMERITI RETIREMENT HEALTH SOLUTIONS

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EMERITI QUALIFIED MEDICAL EXPENSE CLAIM FORM

1. Account Holder Information:

Name:

Social Security #: ___-__-____

Street Address:

City: State: Zip: _____-____

Daytime Phone: ___-___-____ Ext:

2. This claim is being submitted for (Relationship to Account Holder):

☐ Self ☐ Surviving Spouse/Domestic Partner ☐ Surviving Dependent Child or Relative

☐ QMCSO Dependent ☐ Dependent or Spouse

3. If claim is being submitted for anyone other than the Account Holder, please provide the information below:

Name:

Social Security #: ___-__-____

Street Address:

City: State: Zip: _____-____

Daytime Phone: ___-___-____ Ext:

4. If applicable, please check whether this claim and the expenses itemized below are for:

☐ Catastrophic Protection ☐ Terminal Illness

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EMERITI QUALIFIED MEDICAL EXPENSE CLAIM FORM (CONTINUED)

5. Please provide the following information for each expense:

Date of Service	Service Provider (Name of Clinic, Doctor, Pharmacy, Store, etc.)	Description of Expense (Specify if Long-Term Care Premium)	Service Recipient Name	Amount Paid (by Insurance, if any)	Amount Paid by You
			TOTAL REIMBURSEMENT REQUESTED		

6. Certification and Signature. I certify that the expenses for reimbursement requested above were incurred by me (and/or my spouse, and/or dependent domestic partner, and/or eligible dependents, as defined in tax code Section 213) and that the description of these expenses is accurate and meets the guidelines specified under Internal Revenue Code Section 213, and supporting IRS Regulations, or for the payment of Long-Term Care Insurance premiums. I certify that any over-the-counter medication or allowable medical supply requested above was purchased for my (and/or my spouse's, and/or dependent domestic partner's, and/or eligible dependent's, as defined in tax code Section 213) medical care and was not purchased for general good health. I further declare that these expenses have not previously been reimbursed to me nor will I seek reimbursement from any other plan covering health benefits. I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information is guilty of a crime and may be liable for substantial civil penalties. I hold Acclaris, its affiliated companies, officers, and employees harmless for payment of any ineligible expenses presented in such a manner.

If this form is being completed by a legal representative of the recipient (e.g., guardian, power of attorney, executor), please provide the basis of authority and sign Section 6.

Basis of Authority:

Signature: X

Date: