SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT BENEFIT TRUST

1200 Wilshire Boulevard, 5th Floor, Los Angeles, CA 90017
Telephone (562) 463-5050 • FAX (562) 463-5894 • Email smpoatrust@bpabenefits.com

Application for Premium Reimbursement Benefits

INSTRUCTIONS:

1. Read each question carefully.
2. Print answers to applicable questions.
3. Date and sign application.
4. Email completed application to above email address or
5. Mail to: Santa Monica Police Officers' Association Reimbursement Trust, 1200 Wilshire Boulevard, 5th Floor, Los Angeles CA 90017

Name of Eligible Retiree_____
Last First Middle Initial

Address_____
Number and Street City State and Zip Code

Social Security No. _____ Telephone No. _____

Date of Birth _____ Date of Hire _____ Date of Retirement _____

Have any of the following ever-occurred in relationship to your employment with the Santa Monica Police Department:

(1) Separation in your service time; (2) taken a leave of absence; (3) quit and rehired; (4) terminated and reinstated; (5) or any other absence _____ Yes _____ No

If you have answered Yes, please explain each occurrence _____

_____

_____

Are you (or dependent) insured under any other Group medical plan? _____ Yes _____ No

If you answered Yes, provide the following information:

Other Policy Number _____ Telephone No._____

Name of other insurance company or plan _____

Address _____

Are you (or dependent) receiving cash-in-lieu of health coverage from any other source? _____ Yes ____ No

Marital Status: _____ Never Married _____ Married _____ Divorced, remarried
_____ Widowed _____ Separated _____ Divorced, never remarried
_____ Married but cannot locate spouse

Spouse's Name_____

Spouse's Social Security No. _____ Spouse's Date of Birth_____

Spouse's Address/telephone number (if different) _____

_____

Spouse's email address _____

LIST ELIGIBLE DEPENDENTS (26 years of age, or younger)

LAST NAME FIRST NAME	RELATIONSHIP	SEX		DATE OF BIRTH		
		M	F	MO	DAY	YEAR

It is very important that you notify the Administrative Office of any changes in health plans, email addresses, marital status, dependents, addresses and/or telephone numbers.

Reimbursement Categories

Automatic Quarterly Reimbursement

This is solely available to those members who have their insurance premium deducted from their CalPERS pension check *and their premium equals or exceeds their reimbursement* amount under the Trust. Authorization will be requested from you annually. Once you have completed and provided the annual verification form, you will receive your reimbursement automatically each quarter (in the rears). To verify that the Trust reimbursed you correctly, ***you will be required to submit copies of all your CalPERS pension –checks stubs at the end of each year and*** you will also be requested to complete a new verification form.

Be certain that you have enrolled on-line in my|CalPERS Account at my.calpers.ca.gov Call CalPERS at 888-225-7377 with questions. This is the only way you can obtain monthly copies of your CalPERS Statements for cumulative submission at the end of each year.

Individual Receipt Reimbursement

Benefits (up to your maximum monthly benefit) will be reimbursed (in the rears) on a quarterly basis upon presenting proof of payment of individual health care expenses. Proof shall be at least, but not limited to, canceled checks drawn to the name of the medical insurance provider, receipt for payment from the medical insurance provider, etc. Reimbursement will be subject to receipt of adequate documentation and verification, as determined by the Trustees in their sole discretion. Claims for reimbursement must be submitted no later than 90 days from the date on which you made the payment. It is your responsibility to notify the Trustees of your claims for benefits before you are entitled to any benefits. All receipts received by the 10th of the month following each calendar quarter, will be processed no later than the last day of that month.

I hereby apply for premium reimbursement benefits from the Santa Monica Police Officers' Association Benefit Trust.

I declare under penalty of perjury that all of the information contained in this application is true and correct. I understand that the Trustees have the right to recover any payment made to me because of any erroneous information contained in this application.

Signature of Retiree 

_____ Date of Application _____