



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. Do **not** submit claims over two years old or claims for services provided prior to your benefit eligibility date. Claims are processed upon receipt of documents in good order.

Employer Plan Number _____	Employer Name _____	State _____
Participant Name (Last, First and Middle Initial) _____		Address _____
Social Security Number _____ - _____ - _____		Street _____ City _____ State _____ Zip Code _____
Daytime Phone Number (_____) _____ - _____ <small>Area Code</small>		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 A: 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 - PLEASE NOTE: SIGNATURE IS REQUIRED 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 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

FRM080-002-0308-2087-C1333



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Participant Name (Last, First and Middle Initial)

Social Security Number

Part B: 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 the effective date of the change. Otherwise the change will take effect on the next scheduled reimbursement.

READ CAREFULLY - PLEASE NOTE: SIGNATURE IS REQUIRED 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 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