LAS VEGAS METRO
EMPLOYEE *BENEFIT TRUST*
MEDICAL PREMIUMS REIMBURSEMENT CLAIM FORM

☐ Check here for new address

EMPLOYEE INFORMATION — *PLEASE PRINT*

NAME _____
LAST *FIRST* *MIDDLE INITIAL*

HOME ADDRESS _____
STREET *APARTMENT*

_____
CITY *STATE* *ZIP*

SOCIAL SECURITY NUMBER
___/___/___

*EMPLOYEE PN #*_____

DAY PHONE ( ) -

SPOUSE INFORMATION

NAME _____
LAST *FIRST* *MIDDLE INITIAL*

SOCIAL SECURITY NUMBER
___/___/___

DATE OF BIRTH: _____

EMPLOYER _____
(ONLY APPLICABLE IF SPOUSE IS PARTICIPATING IN A GROUP MEDICAL PLAN

Does your spouse receive insurance benefits as an employee or any other organization that receives benefits from LVMEBT ☐Yes ☐No

_____ _____
Name of Insurance Company or HMO Plan in which your spouse is covered.

REIMBURSEMENT INFORMATION

Monthly medical premiums paid by the plan participant and eligible medical expenses.

Month _____ Amount $ _____ ☐*Amount includes Medicare/Governmental Plan premium*

Month _____ Amount $ _____ ☐*Amount includes Medicare/Governmental Plan premium*

Month _____ Amount $ _____ ☐*Amount includes Medicare/Governmental Plan premium*

So that we may process your claim as quickly as possible, please provide us with complete documentation:

1) PERS - Proof of payment (cancelled checks or PERS statement) and monthly premium paid for each month/pay period

2) OTHER - Invoice and proof of payment

Attached is the following proof of payment: (covering the entire period of reimbursement)

☐Cancelled check/Bank Statement ☐PERS statement ☐Medical premium statement ☐Other _____

EMPLOYEE AUTHORIZATION

The undersigned participant in the Plan certifies that the premiums for which reimbursement is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Benefit Plan with respect to such premiums and that such premiums have not been reimbursed, or are not reimbursable under any other plan coverage, or are not part of another employer's group plan.

If filing a reimbursement claim for Medicare or any other government plan such as Tricare, the submission of an annual statement may be used as proof of premium paid. The undersigned participant understands they must submit their 1099 from Medicare at the end of the year for use in reconciling reimbursements. For plans such as Tricare, by signing below, you are attesting that you were enrolled in the plan at the time you requested reimbursement. Any misrepresentation will be considered fraud and you will be liable to repay benefits paid for ineligible expenses.

_____ _____
Employee's Signature Date

RETURN TO PLAN ADMINISTRATOR

UMR – EBT (Flexible Spending Dept.)
P.O. Box 8022
Wausau, WI 54402-8022
Phone: 866-868-1395 – **Select #** (to bypass greeting) *then* **Option 2** (Member) *then* **Option 4** (EBT)
Fax: 877-390-4782
Email: umr-fsa@umr.com