MERCER MARKETPLACE 365℠
RETIREE

ONE-TIME REIMBURSEMENT CLAIM FORM

Use this form for reimbursement of any eligible expenses. You should only choose this option for your premium reimbursement if you have NOT established an Automatic Premium Reimbursement or Recurring Premium Reimbursement for the premium expense. Refer to the back page of this form for instructions on how to complete the information below.

☐ To qualify for reimbursement, you must provide third-party documentation that includes the information on the back of this form. Please CHECK ☑ each reimbursement qualification item as you complete them.

☐ Account Holder SSN (No dashes)

Former Employer Name

Total Pages

Account Holder Last Name:

First Name

Email Address:

Daytime Phone Number (No Dashes):

☐

Date of Service	Type of Expense	Covered Participant Name	Relationship	Amount Requested
01/01/20XX	Medical	John Doe	Spouse	$XXX.XX

☐ PARTICIPANT CERTIFICATION

I, the undersigned, certify that all expenses for which reimbursement is requested by submission of this form were incurred by myself or an eligible dependent and that the expenses have not been reimbursed, or are not reimbursable, from any other source. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, and that if an expense for which payment or reimbursement is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

ACCOUNT HOLDER SIGNATURE

DATE

ONE-TIME REIMBURSEMENT CLAIM FORM

USE THIS FORM for reimbursement of any eligible expenses. You should only choose this option for your premium reimbursement if you have NOT established an Automatic Premium Reimbursement or Recurring Premium Reimbursement claim for the premium expense.

Remember, for a faster, more convenient method, submit online, using the website shown in your Reimbursement Instructional Guide.

Submit the completed claim form and required documentation through one of the following methods:

Mail: Mercer Health & Benefits Admin.,
P.O. Box 14401, Attn: Claims Department
Des Moines, IA 50306-3401

Fax: 1-857-362-2999, Attn: Claims Department

Please include the participant's name in all correspondence, regardless of submission method. If mailing, retain all originals and only mail copies.

A One-Time Reimbursement claim provides a single reimbursement for any eligible expenses. Please refer to your company-specific plan rules for details on medical expenses your plan allows.

Eligible reimbursement requests may include deductibles and copays, and insurance premiums for plans for which Recurring or Automatic Reimbursement is either not available or set up.

Other qualifying out-of-pocket expenses may include Social Security premiums such as Part B related expenses.

☐ Documenting Your Reimbursement Request — All reimbursement requests require third-party documentation showing each item below:

FOR OUT-OF-POCKET EXPENSES:

- ☐ Covered Participant Name (e.g. John Doe)
- ☐ Provider Name
- ☐ Date of Service (e.g. 01/01/20xx)
- ☐ Expense Type (e.g. Medical premium, office visit co-pay, etc.)
- ☐ Proof of Expense Amount (e.g., invoice or receipt from provider that identifies the participant name and service date and description, an Explanation of Benefits from insurer that identifies amount owed by participant)
- ☐ Proof of Payment (e.g., front and back side of cancelled check, receipt, statement from provider showing payment, bank or credit card statement)

FOR PREMIUM EXPENSES:

- ☐ Covered Participant Name (e.g. John Doe)
- ☐ Insurer Name
- ☐ Premium Type (e.g. medical, dental)
  Date of Coverage (e.g. 01/01/20xx–12/31/20xx)
- ☐ Premium amount (e.g., statement or invoice from insurer)
- ☐ Proof of Payment (e.g., front and back side of cancelled check, receipt or statement from insurer, bank or credit card statement)

For Medicare premiums deducted from your Social Security check, use the Social Security Benefit Award Letter issued by the Social Security Administration (SSA) each year, usually during the month of October or November, as your third party documentation. Watch for this document to arrive in the mail.

☐ Account Holder Information:

The account holder may be the retiree or spouse, depending on your plan's rules. If you have a Household account, the primary account holder must sign; if you have an Individual account, the account holder must sign. Please refer to the letter you received from Mercer Marketplace 365 Retiree to understand if you have a Household or Individual account. Call Mercer if you have questions about your account type.

☐ Reimbursement Request Information:

Complete this section to indicate:

- Date of Service
- Type of Coverage (e.g. Medigap)
- Covered Participant Name
- Relationship to the account holder
- Amount Requested, which should be the entire expense you incurred/paid.

☐ Certification Requirement:

Carefully read the certification requirements before signing.

DIRECT DEPOSIT!

Expedite your payments by signing up for direct deposit today. Refer to your Reimbursement Instructional Guide for instructions on how to log into the portal and complete the necessary information for your reimbursements to be made by direct deposit.