Mercer Marketplace 365+℠

ONE-TIME REIMBURSEMENT CLAIM FORM

Use this form for reimbursement of any eligible out-of-pocket expenses. One-Time Reimbursement is available for premium expenses, but is not encouraged. Automatic Premium and Recurring Premium Reimbursements are the most convenient methods for all premium 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 box to ensure you provide complete information and sign the bottom of the form before you send to Mercer.**

☐ Account Holder SSN (No dashes):

Former Employer Name:

Total Pages Included:

Account Holder Last Name:

Account Holder First Name:

Email Address:

Daytime Phone Number (No Dashes):

☐

Date of Service	Type of Expense	Covered Participant Name	Relationship to the Account Holder	Amount Requested
01/01/20XX	Office visit co-pay	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, is compliant with the plan rules set forth by my former employer, 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**

REMINDER – IT IS FASTER AND EASIER TO SUBMIT YOUR CLAIM ONLINE. IF YOU PREFER TO SUBMIT A PAPER FORM, FOLLOW THE DIRECTIONS BELOW.

USE THIS FORM for reimbursement of any eligible expenses. One-Time Reimbursement is available for premium expenses, but is **not** encouraged.

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 or other qualifying out-of-pocket expenses allowed by your plan.

☐ **Step 1: Complete the form** – In the grey area, complete a separate line for each out-of-pocket or premium expense.

☐ **Step 2: Provide documentation of your expense or premium 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. office visit co-pay, etc.)
- ☐ Proof of Expense Amount (e.g. invoice or receipt from provider that identifies the participant name, service date and description; an Explanation of Benefits from insurer that identifies amount owed by participant).*

*For an eligible prescription drug expense, all pages of the Explanation of Benefits must be submitted as the proof of expense.

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)

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.**

☐ **Step 3 - Certification Requirement:**
Carefully read the certification requirements before signing. **Your reimbursement request cannot be processed without the signature of the account holder.**

☐ **Account Holder Information:**
The account holder is determined by your plan's rules. If you have a Household account, the primary account holder must sign; if you have an Individual account, the individual account holder must sign his or her own form. 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.

Relationship: Include the relationship between the account holder and the person requesting the reimbursement (e.g. self).

Type of Expense: Refer to your Reimbursement Instructional Guide (e.g. copay, medical premium).

Date of Service: This is the date the expense was incurred. For premiums include the date range of the coverage - usually January 1st of each new year or the effective date of the coverage period which typically ends December 31st.

Amount Requested: This is the amount you are requesting to be reimbursed. This must not exceed the amount that is noted on the supporting document. If you request an amount higher than your account balance, any amount not reimbursed will be pended and reimbursed in a future reimbursement. You may request an amount that is less than the total premium or expense.

Direct Deposit!
Expedite your payments by signing up for direct deposit. Refer to your Reimbursement Instructional Guide for instructions on how to log into the portal and complete the steps to receive your reimbursement via direct deposit.

Submit the completed claim form through one of the following methods:

Mail: Mercer Health & Benefits Admin., Attn: Claims Department, P.O. Box 14401, 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.