Kapnick

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CDPSU RETIREE HEALTH REIMBURSEMENT FORM

RETIREE INFORMATION

Retiree's Name: _____ Last 4 of Social Security Number: _____
Last First

Address (if changed): _____ Phone: _____

MEDICAL CARE

Name of Family Member Expense Covers	Description of Expense	Date of Service	Amount
(List any additional items on a separate sheet)		**Total Expenses:**	**$**

Will any of the above expenses be covered or reimbursed from any other source? (e.g., Blue Cross, an HMO, or another Group Health Plan) ☐ **No** ☐ **Yes** *If yes, you MUST attached copies of the other plan's Explanation of Benefits form.*

CERTIFICATION

I certify that there are no false statements on this form. I understand that this plan is subject to provisions of several Internal Revenue Code Sections and that all tax consequences of this plan are my sole responsibility. Also, I certify that the expenses that I am submitting are not reimbursable under any other benefit plan.

_____ _____
Retiree's Signature Date

Instructions:

1. Complete the Retiree Information section.
2. Complete the Medical Care section as necessary.
3. **Attach supporting documentation** as described below:
   - **Explanation of Benefits Form (EOB):**
     This is the form you receive each time you or a health care provider submits claims for payment to your medical, dental, or other health care plan.
   - **Receipt:**
     A receipt from a medical provider (or other provider of covered goods or services) showing the amount paid and a description of the item or service.
4. **Sign** and date this form.
5. **Mail, email, or fax the completed, signed form and attachments** to the contact information in the upper right corner of this form.
6. If you have any questions regarding your reimbursement account or claims, please call **Kapnick Insurance Group** at phone number (877) 456-4306.

Additional claim forms are available in the online portal and may also be requested by contacting Kapnick Insurance Group by phone or via email at the contact information located on the upper right corner of this form.