



**NATIONAL FRATERNAL ORDER OF POLICE
VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) MEMBER PLAN
BENEFITS REIMBURSEMENT REQUEST FORM - Page 1 of 2**

Member
Plan

- 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**. Supporting documentation (originals only, no copies) may consist of:
 - Bills
 - Explanation of Benefits
 - Premium Notices
 - Receipts
- A separate form must be completed for each eligible claimant.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, as well as the name of the claimant.

PLEASE NOTE: 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.

RHS Plan Number 8 0 1 0 0 0	RHS Plan Name National Fraternal Order of Police RHS Plan	RHS Division Number* _____
		<i>* Available from your Lodge or ICMA-RC at 1-866-747-NFOP (1-866-747-6367).</i>

Participant Name (Last, First and Middle Initial)	Mailing Address
Social Security Number _____ - _____ - _____	Street _____ City _____
Daytime Phone Number (____) _____ - _____ <small>Area Code</small>	State _____ Zip Code _____
NOTE: If this is a new address, please contact ICMA-RC at 1-800-669-7400 to update your address. Your check will be mailed to the address on file with ICMA-RC.	

Claim for: Self Spouse Dependent Child Other Dependent Non-Spouse or Non-Dependent Beneficiary

Claimant's Full Name (Last, First and Middle Initial)	Claimant's Social Security Number
_____	_____ - _____ - _____

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*	Provider (e.g. doctor name/ pharmacy name)	Description of Service	Amount To be Reimbursed

* Incurred date is the date of service, not the billing or payment date. Total reimbursement request: \$ _____

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 accountholder. 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.

PLEASE RETAIN A COPY FOR YOUR RECORDS *(Continued on back)*



**NATIONAL FRATERNAL ORDER OF POLICE
VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) MEMBER PLAN
BENEFITS REIMBURSEMENT REQUEST FORM - Page 2 of 2**

Member
Plan

Participant Name (Last, First and Middle Initial) _____

Social Security Number _____ - _____ - _____

RHS Plan Number

8 0 1 0 0 0

1. Begin recurring reimbursement of \$ _____

Beginning Date: Insert date you wish payments to begin ____ / ____ / ____
Mo Day Year

Frequency (Check one): Annual Quarterly Monthly Weekly

Ending Date: Insert date automated payments should cease ____ / ____ / ____
Mo Day Year

2. Change recurring payment amount to \$ _____

Effective date of change ____ / ____ / ____
Mo Day Year

3. End recurring payment of \$ _____

Ending Date: Insert date automated payments should cease ____ / ____ / ____
Mo 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. Your account balance may be obtained via Account Access (www.rhsnfop.org) or VantageLine at 1-866-747-NFOP (1-866-747-6367).

For Meritain Health Use Only	
PM	
PD	
PL	
PC	

READ CAREFULLY

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, the participant's eligible dependents, or a designated beneficiary (after the participant's death only) 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.

Signature

Date

PLEASE RETAIN A COPY FOR YOUR RECORDS