WORKTERRA
a CAREERBUILDER company

Retiree Reimbursement Account

σ How to File a Claim

- Fill out the claim form completely. Please print clearly, or type, all requested information on the claim form.
- Be sure to note if there has been an address change. There is a checkbox on the claim form to indicate that the address listed is new.
- Be sure your calculations of the amount to be reimbursed are correct, and that they match the receipts or the Explanation of Benefits from the insurance company.
- Attach receipts for all eligible expenses.
- **Receipts MUST include the following information:**
  - name of the patient (you, your spouse or dependent);
  - the date the service was provided;
  - the name of the service provider;
  - a description of the service;
  - the amount/cost of the item or service provided
- **TOP 2 REASONS THAT CLAIMS ARE DENIED;**
  - Cancelled checks should not be used as proof of payment (not allowed by IRS) as the check does not provide information required for proof of service as noted above.
  - Statement from provider listing only payments made, do not provide all the information needed as described above (dates / description of service must be included per the IRS)
- Be sure all expenses were incurred during the Plan Year before submitting.
- Be sure the expenses were not previously submitted.
- Make sure that all of the information provided on the claim form (particularly your name, address) is clearly legible. Claim forms that cannot be read are filed away until they are identified.
- Retain a copy of all claims forms and receipts, submitted to Workterra, for your personal files. You will be charged a fee for Workterra copying submitted information.
- If your claim cannot be processed, you will be notified in writing, explaining the reason and requesting the necessary information needed to process your claim.

σ Workterra Account Balance and Claims Status

Customer Service assistance is available Monday thru Friday, 9am to 5pm, Pacific Standard Time at: **(888)327-2770** or you can e-mail them at **custserv@workterra.com**. You can also login into the Consumer Portal using your assigned username and password at: https://workterra.lh1ondemand.com/Login.aspx, for up to the minute account information. Please visit the "member center" at **http://workterra.com/member-center.html** for other general information.

Santa Rosa
Retiree Reimbursement Account

CLAIM FORM

1. Instructions: *(incomplete claim forms will not be processed)*

- Complete the Retiree Information requested under Section2.
- Complete Section 3 and attach an itemized bill from the Provider.
- Read the Retiree Authorization carefully and sign under Section 4.
- Keep complete copies of everything submitted to Workterra for your records.
- Completed Claim Forms should be mailed to:

Workterra
PO Box 11657
Pleasanton, CA 94588
Fax: (925) 460-3929

2. Plan / Retiree Information

☐ *check this box, if the address listed below is new*

City Of Santa Rosa Post Retirement Medical Benefits Plan

_____ _____
Retiree Name Social Security Number

_____ _____ _____ _____
Retiree Street Address City State Zip Code

3. MEDICAL EXPENSES

Name of Family Member	Relationship To Retiree	Date of Service	Description of Expenses	Amount Requested
σ **Enter the total amount requested for reimbursement on this line and attach receipts:**				

4. Retiree Authorization

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under the Santa Rosa Post Retirement Medical Benefits Plan and that these expenses have been incurred during the Plan Year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Plan to reimburse the amount requested from my Benefits Plan Account.

Retiree Signature: _____ **Date**: _____

Retiree Reimbursement Account
Recurring Expense Claim Form

This form is for use by participants in the Santa Rosa Retiree Reimbursement Account. This claim form is used for recurring expenses (i.e., medical premium). Please attach a copy of the carrier bill to this claim form. A new claim form must be resubmitted at the beginning of every plan year. If you have questions about this form, or about the plan, e-mail Workterra at custserv@workterra.com, or call us at 925-460-3910 /888-327-2770.

City of Santa Rosa Post Retirement Medical Benefits Plan ☐ *check this box, if the address listed below is new*

_____ _____
Retiree (Plan Participant) Name SSN

_____ _____
Retiree Address Retiree Phone Number

_____
City, State, Zip Code

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1. Carrier/Service Provider	**Type of Premium (health, dental)** (e.g.: health, dental, long term care)	**Monthly Cost**
A _____	_____	$_____
B _____	_____	$_____
C _____	_____	$_____

2. Dates of Service for above premiums

(Example: from: 1/1/18 to: 12/31/18)

A. From: _____ /_____ /_____ **To:** _____ /_____ /_____
B. From: _____ /_____ /_____ **To:** _____ /_____ /_____
C. From: _____ /_____ /_____ **To:** _____ /_____ /_____

3. Retiree Authorization

This form needs to be completed once during the period for which the services are provided. If there is any change to the above information a new form must be submitted in its place. A new form must be submitted for any other period not included in the dates of service (2) portion noted above. As a participant in this plan, you are responsible for providing correct information and that the amounts you request for reimbursement for this plan are accurate and for eligible expenses.

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under the Santa Rosa Post Retirement Medical Benefits Plan and that these expenses have been incurred during the Plan Year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Plan to reimburse the amount requested from my Benefits Plan Account.

Retiree Signature: _____ _____ / _____ / _____
Date Form Completed

Completed Claim Forms should be mailed or faxed to:

Workterra
PO BOX 11657
Pleasanton, CA 94588
Fax: (925) 460-3929

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DIRECT DEPOSIT FORM AUTHORIZATION AGREEMENT

Mail completed forms to WORKTERRA, *PO Box 11657, Pleasanton, CA 94588 or fax to: 925-460-3929*

The fastest way to add, change, or stop direct deposit is via the consumer portal at https://workterra.lh1ondemand.com. If you do not wish to utilize the consumer portal then this form can be used to initiate, change or cancel your direct deposit. This service alleviates the time spent waiting for a check in the mail and is available to all plan participants. Please note – this form must be sent to WORKTERRA two weeks before the reimbursement method is changed if you choose not to enter the information via the consumer portal.

All requests for Direct Deposit must be submitted on this form and include a voided check for the account. Forms without a voided check attached will not be processed. Deposit slips are not acceptable as appropriate routing numbers may not be available.

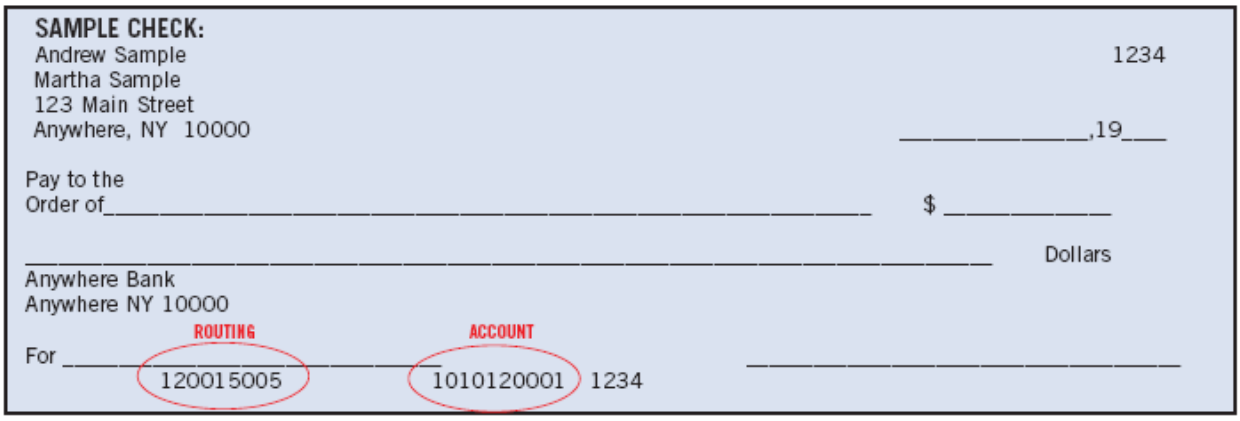
Reimbursement will only occur if you have submitted a claim to WORKTERRA with receipts for eligible expenses. WORKTERRA does not guarantee payments into your account on any date. WORKTERRA is not responsible for bank charges of any type that you may incur for direct deposit transactions. Do NOT assume that a payment has been made to your account at any time. You are solely responsible for checking with your bank as to the deposit amount and date of direct deposits made to your account. You may use the on-line account balance system (through WORKTERRA's web site) or contact WORKTERRA Customer Service to check the status of your flexible spending account.

By submitting this form, you understand that your claims reimbursements will be deposited into the listed account. Please place an x in the appropriate box:

❍ Initiate Direct Deposit ❍ Change Account ❍ Cancel Direct Deposit

Employer Name:	
Employee Name:	SSN:
Employee Address:	Daytime Phone:
Bank Name & Address:	
Bank Routing #:	Bank Account #:
❍ Checking Account ❍ Savings Account	
Authorizing Signature:	

For assistance in finding routing and account numbers please see below:



Routing Number must be nine digits. If the first two digits are not 01 through 12 or 21 through 32, your direct deposit request will be rejected. **The Account Number** can be up to 17 characters (both numbers and letters) - include hyphens but omit spaces and special symbols.