Reimbursement Form

Mail: P.O. Box 981155, El Paso, TX 79998-1155 Fax: 1-855-321-2605

① Employer Name: OPERS

Total Pages:

Account Holder Name – Last:

First:

Middle:

Social Security Number: ___ - ___ - ____

Zip Code: _____

②

Date of Service MM/DD/YYYY	Type of Coverage	Covered Participant Name	Relationship e.g., self	Amount Requested
01/01/2015	*Medical*	*John Doe*	*Spouse*	*$XXX.XX*
			Total Amount Requested	

③ By signing below, I certify that the information provided on this reimbursement form is correct and that the expenses for which I am requesting or for which I am providing validation: were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement. An eligible dependent must be someone who qualifies as a tax dependent under IRC 152 AND is a spouse, OR a child under age 26, OR a grandchild born to a minor child if court ordered to provide coverage.

Account Holder Signature

Date

④ To qualify for your reimbursement you must provide a third party document that includes the information to the right.

Please CHECK ☑ Each Reimbursement Qualification item as you complete them.

☑ Does your document(s) include these items?

- ☐ Covered Participant Name (e.g., John Doe)
- ☐ Provider Name (e.g., AARP)
- ☐ Date of Service (e.g., 01/01/2015)
- ☐ Description of Coverage (e.g., Medigap)
- ☐ Proof of Payment