Alerus Retirement and Benefits
PO Box 64535 • St. Paul, MN 55164-0535
866.808.7823 (option 3)
www.mersofmich.com

Wayne County Health Care Savings Program Reimbursement Claim

Please print clearly • See attached guide for details • Retain a copy for your records

This form is used to request reimbursement using a paper form. For the most secure and quickest method of reimbursement, consider managing your request electronically. If you need assistance in setting up a myMERS account, contact MERS at 800.767.6377.

- This form can be used for a one-time reimbursement or to set up a recurring payment.
- For participants who receive a monthly stipend that is less than the recurring amount, be sure to note if you want the amount that is equal to your stipend, or for the full amount of the premium. Otherwise, if the premium claim exceeds your account balance at the time of processing, you will receive partial reimbursement the following month.

For example;

John Smith receives a stipend amount of $145 and his insurance premium is $170.10. Since his premium is more than the stipend amount he receives monthly, the remaining $24.90 will be reimbursed the following month out of the stipend amount deposited the next month. If John wants to only receive his full stipend amount (i.e. $145), John should write in the stipend amount, not the premium amount.

1. Information about you

Last name*	First name*	Social Security Number*	Phone number (with area code)*

Mailing address*	City*	State*	Zip*

Be sure to keep your address information up to date by logging into your myMERS account; processing delays will occur if the information on file is different than what is on this form.

Name of employer*
Wayne County –Municipality #8261; Plan # 301675

2. Reimbursement/payment election

☐ One-Time Reimbursement

Use this section to indicate any one-time reimbursement details by listing each in a separate line item in the table below. A copy of the third-party receipt showing payment and the associated bill or statement detailing the expense incurred and the date of service must be provided to complete processing. Expenses may **not** be those covered by insurance.

Date(s) Provided	Expense (Co-pays, Rx, Dentist, etc.)	Provided to (Name, relationship)	Total
			$
			$
			$
			$
			$
			$
	Attach additional forms if needed	**Claim Total**	$

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Last name* (please print clearly)	Social Security Number*

☐ Recurring Expense

To schedule reimbursement for a recurring expense that is paid monthly (such as insurance premiums or Medicare Part B), use the grid below. Each month should be itemized on its own line below. If the amount entered below exceeds the account balance, the following month's deposit will be used to make up for any difference. To reduce confusion, enter the amount below that is equal to the the amount of your stipend.

Coverage Type (Medical, Dental, Medicare, etc.)	Provided to (Name, relationship)	Month of coverage (12 months max)	Monthly Amount
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$

A different reimbursement form should be completed for each type of premium. For example, if you have monthly premiums for dental and medical, complete separate forms for each.

Recurring expenses may only run for 12 months, after that time a new form will be required.

DOCUMENTATION REQUIRED:

For Medicare Part B: *Annual Social Security Statement*.

Can't locate this? Visit ssa.gov for instructions or call them at: 800.772.1213.

3. Payment direct to provider

Skip this section if reimbursement is being directed to you. Please complete all required information – incomplete submissions may result in delays in processing this form.

Provider name*	Provider account number*

Provider address line 1*	Provider address line 2

Provider city*	Provider state*	Provider zip*

4. Claimant's certification and signature

1. I certify that all expenses for which reimbursement of payment is claimed by submission of this form were incurred either by me or by my dependent(s).
2. I certify that the medical expenses incurred by me or by my dependent(s) are "qualifying expenses" as defined by the Internal Revenue Code, Section 213(d). I understand that if these medical expenses are deemed not to be qualified medical expenses, I may be liable for payment of all related taxes on amounts paid by the Plan related to such unqualified expenses.
3. I certify that the medical expenses claimed have not been reimbursed or cannot be reimbursed under any other coverage.
4. I take full responsibility for the accuracy and veracity of all the information I have provided. I certify I am entitled to these benefits.
5. I understand that all reimbursements are made by Direct Deposit from MERS HCSP and must go into the same account.

Signature of member*	Date (mm/dd/yyyy)*

* Required field

Please mail completed form and documentation to:

Alerus Retirement and Benefits
ATTN: Health Benefits Department
PO Box 64535
St. Paul, MN 55164-0535

Questions? Please contact us at 866.808.7823 (option 3).