Mercer Marketplace 365+℠

REIMBURSEMENT CLAIM FORM

To qualify for reimbursement, you must provide third-party documentation that includes the information on page 2 of this form. Please ensure you provide complete information and **sign the Participant Certification section of the form before you send to Mercer Marketplace.**

☐ **One-Time Payment**
☐ **Recurring Payment***

*Recurring claims must be resubmitted on a yearly basis or if there is a change in your premium amount or the amount being requested.

Account Holder SSN (No dashes):

Former Employer Name:

Total Pages Included:

Account Holder Last Name:

Account Holder First Name:

Email Address:

Daytime Phone Number (No Dashes):

Date of Service (start date-end date)	Type of Expense/Premium Type	Covered Participant Name	Relationship to the Account Holder	Amount Requested (One-time or Recurring Payment)	Recurring Claim* ONLY: Total Number of Monthly Payments
01/01/20XX – 01-31-20XX	Office visit co-pay	John Doe	Spouse	$XXX.XX	

PARTICIPANT CERTIFICATION

ONE-TIME Payment: I, the undersigned, certify that all expenses for which reimbursement is requested by submission of this form were incurred by myself or an eligible dependent and that the expenses have not been reimbursed, or are not reimbursable, from any other source. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, is compliant with the plan rules set forth by my former employer, and that if an expense for which payment or reimbursement is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

RECURRING Payment: I have read this document and understand and confirm that as a Participant in the Plan, premiums itemized above for myself and any eligible dependents will be deducted from my subsidy Account and reimbursed to me directly every month beginning _____ (date). I understand the Plan will reimburse me based on the expenses I submit provided there are sufficient funds in my subsidy Account. I understand it is my sole responsibility to inform the Plan administrator if my coverage ends or my monthly premium amount changes from the amount shown above. I accept full liability for timely notification of any changes. I, the undersigned, certify that all expenses for which reimbursement is requested by submission of this form were incurred by myself or an eligible dependent and that the expenses have not been reimbursed, or are not reimbursable, from any other source. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, is compliant with the plan rules set forth by my former employer, and that if an expense for which payment or reimbursement is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

ACCOUNT HOLDER SIGNATURE **DATE**

USE THIS FORM for reimbursement of any eligible expenses one-time or on a recurring basis. You shouldonly choose the recurring method of premium reimbursement if you have **not** established an Automatic Premium Reimbursement.

For a faster more convenient method, submit online at https://yourflexbenefits.mercermarketplace365.com as shown in your Reimbursement Instructional Guide. Alternatively, you may submit your completed claim form through one of the following methods:

Mail: Mercer Marketplace Claims Department
P.O. Box 424
Escondido, CA 92033

Fax: 1-844-791-8319, Attn: Claims Department

Please include the participant's name in all correspondence, regardless of submission method. If mailing, retain all originals and only mail copies.

An approved One-Time Payment claim provides a single reimbursement for any eligible expenses. An approved Recurring Payment claim provides ongoing monthly reimbursements for premiums for the requested number of monthly payments.

Please refer to your company-specific plan rules for details on medical expenses your plan allows. Eligible reimbursement requests may include deductibles and copays or other qualifying out-of-pocket expenses such as Medicare Part B premium if allowed by your plan.

Documenting your reimbursement – All reimbursement requests require third-party documentation showing each item below:

FOR OUT-OF-POCKET EXPENSES:

- Covered Participant Name (e.g., John Doe)
- Provider Name
- Date of Service (e.g., 01/01/20xx)
- Expense Type (e.g., medical premium, office visit co-pay, etc.)
- Proof of Expense Amount (e.g., invoice or receipt from provider that identifies the participant's name and service date and description, an Explanation of Benefits from insurer that identifies amount owed by participant

FOR PREMIUM EXPENSES:

- Covered Participant Name (e.g., John Doe)
- Insurer Name
- Premium Type (e.g., medical, dental)
- Date of Coverage (e.g., 01/01/20xx–12/31/20xx)
- Premium amount (e.g., statement or invoice from insurer)

If eligible under your plan, documentation for Medicare premiums includes the Social Security Benefit Award Letter issued by the Social Security Administration (SSA) each year, usually during the month of October or November, as your third-party documentation. **Watch for this document to arrive in the mail.**

Account Holder Information:

The account holder may be the retiree or spouse, depending on your plan's rules. If you have a Household account, the primary account holder must sign; if you have an Individual account, the individual account holder must sign his or her own form. Please refer to the letter you received from Mercer Marketplace 365+ Retiree to understand if you have a Household or Individual account. Call Mercer if you have questions about your account type.

Reimbursement Request Information:

COMPLETE THIS SECTION TO INDICATE

- Date of Service (For premium expenses due on the first of the month, the date of service listed should be the first of that month, e.g., 01/01/20xx)
- Type of Coverage (e.g., Medigap)
- Covered Participant Name
- Relationship to the account holder
- Amount Requested
- For recurring claims, enter the total number of monthly recurrences

Certification Requirement:

Carefully read the certification requirements before signing. Your reimbursement request cannot be processed without the signature of the account holder.

Direct Deposit!

Expedite your payments by signing up for direct deposit. Refer to your Reimbursement Instructional Guide for instructions on how to log into the portal and complete the steps to receive your reimbursement via direct deposit.