



Deferred Compensation Plan

City of Kansas City Claim Form

Post Employment Health Plan (PEHP)

See Important Information on page 3 before completing this form

1. Plan Information

Plan Name: _____ Plan Number: _____

2. Personal Information (please print)

Name: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Preferred Method of Contact: Home Phone Work Phone Email

3. Reimbursement Direction (all fields REQUIRED)

NOTE: Please attach proof of policy type, amount, and period of paid medical expenses/proof of paid premium expenses (i.e. medical bills, prescription receipts, health insurance statements)

Reimbursement is for: Self Spouse Dependent(s)

Reimbursement amount: \$ _____

Type of Reimbursement: One-time Monthly Quarterly Semi-Annually Annually

NOTES: Insurance premium payment will default to one time if a frequency is not selected. Any new ongoing insurance premium request will cancel any current ongoing PEHP systematic withdrawals.

4. Spouse/Dependant Information

1. Spouse/Dependent Name: _____ Date of Birth: _____

Relationship: _____

2. Dependent Name: _____ Date of Birth: _____

Relationship: _____

3. Dependent Name: _____ Date of Birth: _____

Relationship: _____

4. Dependent Name: _____ Date of Birth: _____

Relationship: _____

NOTE: for additional dependents, please attach information on a separate page with the Name, Date of Birth, and Relationship of each dependent.

5. Plan Authorization

This section must be completed by an Authorized Representative from the Human Resources Retirement Division, only if this is an initial payout request.

Name (please print): _____ Separation from Service Date: _____

Human Resources Retirement Division Authorized Signature: _____

Date Signed: _____

6. Payment Method

Select One:

- ACH Instructions on File - Send funds to my bank account that Nationwide has on file.
- Send check by first class mail to my address of record. Allow 5 to 10 business days from process date for delivery. (Default option, if no other option is selected)
- Direct Deposit ACH (complete information below)

Financial Institution Information:

Bank Name _____

ABA (routing) Number _____

Account Number _____

Account Type: Checking Savings

NOTE: If left blank, we will default to checking.

John Doe
123 Main Street Ph. (614) 555-1212
Hometown, OH 45678

Date _____ 1492

PAY TO THE ORDER OF _____ \$ _____
_____ DOLLARS

Money Bank, Inc.
321 Main Street
Hometown, OH 45678

MEMO _____

⑆ 123456789 ⑆ 000012345678 ⑆ 1492

9-digit ABA routing number Checking Account Number Check Number

NOTE: Direct Deposit is only offered through members of the Automatic Clearing House (ACH). We cannot accept a deposit slip or starter check for banking numbers.

Is this account associated with a brokerage firm or other investment firm? Yes No

If yes, have you confirmed that the ABA and account numbers are correct? Yes No

I hereby authorize Nationwide to initiate automatic deposits to my account at the financial institution named above. In the event an error is made, I authorize Nationwide to make a corrective reversal from this account. Further, I agree not to hold Nationwide responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. This agreement will remain in effect until Nationwide receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit authorization form to Nationwide. In the event this direct deposit authorization form is incomplete or contains incorrect information, I understand a check will be issued to my address of record.

7. Signature

I agree that this claim represents qualifying health insurance premium expenses and that I have separated from service with the employer sponsoring the plan. My signature below confirms my understanding and agreement with this requirement. I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable event by the IRS. **NOTE: On-going reimbursements will continue automatically until NRS is notified to stop the reimbursement.**

Participant or Claimant:

Signature: _____ Date Signed: _____



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City of Kansas City Claim Form Important Information Post Employment Health Plan (PEHP)

Information

A Post Employment Health Plan (PEHP) account is a benefit that has been established for you, your spouse, and/or your qualified dependents, by your employer when you separate from service. Your PEHP account will be used to provide for reimbursement of qualified post employment expenses for medical insurance, which are incurred post-employment.

If you have an account for health care insurance premiums, your account will be automatically paid out when you submit a claim for the following approvable post-employment insurance expenses:

- Health care premiums
- Medicare premiums (subject to plan guidelines)
- Medicare Supplemental Insurance Premiums (Medi-Gap)
- Eye care policy premiums
- Dental care policy premiums
- Prescription drug policy premiums
- Health care premiums - provided under your employer's COBRA benefits
- Long-term health care premium expense

NOTE: Please provide proof of policy type, amount, and period.

If this is an adjustment to an existing claim you will need to include an updated policy showing the new amount for each premium being requested.

You must complete Section 6 if you prefer to be reimbursed directly to your bank account.

Submission Instructions

Mail your completed form and supporting documents to:

Nationwide Retirement Solutions
PO Box 182797
Columbus, Ohio 43218

Or send via **Fax: 877-677-4329**

Questions?

Service Center: 866-350-KCMO