



# City of Scottsdale Retiree Welfare Benefits Plan

## Post Employment Health Plan (PEHP)

Service Center: 855-826-5400 • Fax: 877-677-4329 • scottsdale457.com

See Important Information on page 3 before completing this form

### 1. Employer Information

Employer Name: City of Scottsdale Retiree Welfare Benefits Plan Employer Number: 0056705001

### 2. Personal Information (please print)

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Method of Contact:  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)**

- Request a New Reimbursement (complete the rest of the document)
- Cancel my Pending or Existing Reimbursement (proceed to Section 8, sign and return the document)
- Stop Systematic Payment
- Change Systematic Payment

Reimbursement is for:  Self  Spouse  Dependent(s)

Reimbursement amount: \$ \_\_\_\_\_ Systematic Start Date: \_\_\_\_\_

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.

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## 5. 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. (916) 555-1212  
Hometown, CA 98765

Date \_\_\_\_\_ 1492

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ DOLLARS

Money Bank, Inc.  
321 Main Street  
Hometown, CA 98765

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.

## 6. Signature

I agree that this claim represents qualifying medical expenses not covered/reimbursed by insurance 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: \_\_\_\_\_



## Claim Form Important Information Post Employment Health Plan (PEHP)

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### 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 care, including expenses for medical insurance, which are incurred during post-employment period.

**If you have an account for qualifying medical care expenses, your account will be automatically paid out when you submit a claim for the following approvable medical expenses:**

- Medical co-pay or deductibles that are your responsibility, but are not reimbursed by your insurance plan;
- Health care premiums (pre-tax premiums are ineligible)
- Eye care, including examinations, glasses and contact lenses
- Routine physical examinations
- Dental care, including routine dental check-ups with orthodontia, and dentures
- Hearing care, including examinations and hearing aids
- Prescription drugs

**For more detailed information regarding qualified medical expenses, refer to Publication 502, available on the Internal Revenue Service website at [irs.gov](http://irs.gov).**

**NOTE: Please submit itemized invoices of paid medical expenses with your claim.**

**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 (pre-tax premiums are ineligible)
- 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 5 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**

**Email:** [rpublic@nationwide.com](mailto:rpublic@nationwide.com)

**Fax:** 877-677-4329

Questions?

**Service Center:** 855-826-5400