CITY OF PHOENIX DEFERRED COMPENSATION PLANS
Building your future together

Nationwide®

City of Phoenix PEHP
Claim Form

Information

Your employer has established a Post Employment Health Plan (PEHP) account on your behalf. A PEHP account can be used to reimburse your qualified medical care expenses or those of your spouse or dependents after severance from employment. Reimbursement of the following is permitted:

This is a Universal Medical Expenses Account (05). 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;
- 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.

NOTE: IN ORDER FOR YOUR CLAIM TO BE PAID OUT, YOU MUST ATTACH RECEIPTS OF PAID MEDICAL EXPENSES.

Submission Instructions

Mail, email or fax your completed form and supporting documents to:

Mail: Nationwide Retirement Solutions
PO Box 182797
Columbus, Ohio 43218

Email: rpublic@nationwide.com

Fax: 877-677-4329

Questions?

Service Center: 800-891-4749

Local Office: 602-266-2733

Website: phoenixdcp.com

Complete the form on the reverse of this page

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Personal Information

Employer Name: City of Phoenix Plan Number: 0039182

Name: _____

Date of Birth: _____ SSN or Account Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

Reimbursement

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

Reimbursement is for: ☐ Self ☐ Spouse ☐ Dependent

NOTE: for multiple dependents, please attach information on a separate page.

Spouse/Dependent Name: _____ Date of Birth: _____

Relationship: _____ Reimbursement amount: $_____

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

If applicable to this claim, recurring payments can be made. Would you like recurring payments established for this claim?
☐ Yes ☐ No

III. Automated Deposit Authorization

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.

NOTE: Your financial institution must be a member of the Automatic Clearing House (ACH). Call your financial institution if you are unsure. **PLEASE ATTACH A VOIDED CHECK OR DEPOSIT SLIP.**

Name of Financial Institution: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Account Number: _____ Routing Number: _____

Account Type: ☐ Checking ☐ Savings

Signature

I agree that this claim represents qualifying medical expenses not covered or reimbursed by my insurance plan, that I have not previously sought reimbursement from my insurance plan, that I have severed employment from the city of Phoenix. 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 to me by the IRS.

Participant or Claimant Signature: _____ Date Signed: _____