City of Phoenix
Law Enforcement Association PEHP
Claim Form

Information

As an active city of Phoenix employee who is a member of the Phoenix Law Enforcement Association (PLEA), a PLEA Post Employment Health Plan (PEHP) account has been established 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 or fax your completed form and supporting documents to:

Nationwide Retirement Solutions
PO Box 182797
Columbus, Ohio 43218

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

CITY OF PHOENIX DEFERRED COMPENSATION PLANS
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Nationwide®

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I. Personal Information

Name: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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

Employer Name: **City of Phoenix PLEA** Plan Number: **0038495001**

Email Address: _____

II. 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 Retirement Solutions, hereinafter called COMPANY, to initiate credit entries to my account indicated below in the financial institution named below. I specifically agree to hold harmless and not seek recovery against the COMPANY, its officers, directors, employees and agents for any loss which I may sustain due to the actions or inactions of my designated financial institution or the information contained in this form. The credit entries will represent payments due to me under the Post Employment Health Plan. Payment of my PEHP claims will begin within 30-45 days after receipt of this notification, after which all payments will be made to my account within **3 business days** following the withdrawal. By signing this form, I agree to direct my executors, administrators, or assignees to refund any payments which are made for any period following my death so they may be redistributed to my beneficiary if applicable. Note: Your financial institution must be a member of the Automatic Clearing House (ACH). Call your financial institution if you are unsure.

Name of Financial Institution: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Account Number: _____ Routing Number: _____

Account Type: ☐ Checking ☐ Savings **NOTE: PLEASE ATTACH A VOIDED CHECK OR DEPOSIT SLIP**

IV. 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, and that I maintained membership in PLEA for at least a portion of that employment. 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: _____