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
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 VOIED CHECK OR DEPOSIT SLIP

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

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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: ____________

City of Phoenix
Law Enforcement Association PEHP
Claim Form

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: ___________________________

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