Nationwide®

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

Service Center: 877-677-3678 • Fax: 877-677-4329 • nrsforu.com

**See Important Information on page 3 before completing this form**

## 1. Employer Information

Employer Name: County of San Luis Obispo Employer Number: 0056557001

## 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. Employer Authorization

**This section must be completed by a Certifying Official in your Payroll Department, only if this is an initial payout request.**

Signature: _____ Separation from Service Date: _____

## 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

_____

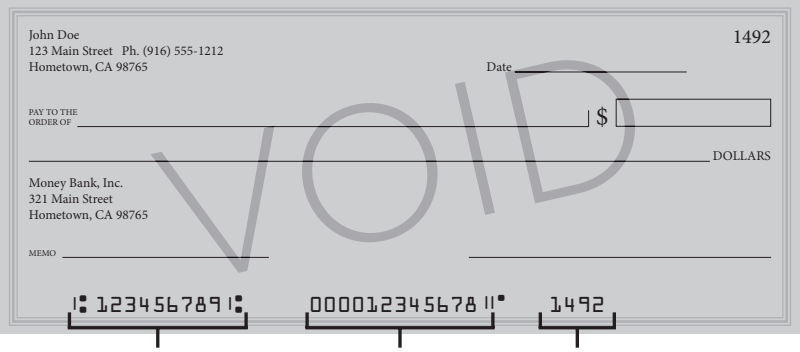
ABA (routing) Number

_____

Account Number

Account Type: ☐ Checking ☐ Savings

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




**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. Authorization to Reimburse Employer Directly (this is for ongoing insurance premiums)

Routing Number: _____ Account Number: _____

Employer Mailing Address: _____

City: _____ State: _____ Zip: _____

Authorized Representative Signature: _____

Position/Title: _____ Date: _____

## 8. 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: _____

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# 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;
- 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 www.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
- 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.

You must complete Section 7 if you prefer to have your former employer reimbursed directly for insurance premiums they pay on your behalf.

## 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:** 877-677-3678