MASSACHUSETTS/MOSES HEALTH AND WELFARE TRUST FUND COMMONWEALTH HEALTHCARE MITIGATION REIMBURSEMENT REQUEST FOR FISCAL YEAR 2019	**Official Use Only** Log: Date received: Total:

Employee Full Name:			
Address: Street, PO Box/Apt#	City	State	Zip
☐ Check box if you changed addresses in the past year	E-mail Address:		
Phone: Home:	Work:	Ext (if applicable):	
Name of Dept./Agency/Authority:			
Name of Employee's Health Insurance:			
Yes ☐ No ☐ Do you, your spouse, or your dependents receive Healthcare benefits from another insurer? If Yes Name of Insurer:			
Yes ☐ No ☐ Were all of the expenses documented below incurred while you were employed as a Commonwealth Unit 9 employee represented by MOSES in Fiscal Year 2019?			
Yes ☐ No ☐ Were all of the expenses documented below incurred by yourself, your spouse, or your dependent?			
Yes ☐ No ☐ N/A ☐ Was your spouse or dependent also a Commonwealth Unit 9 employee in Fiscal Year 2019?			

Attach summary documents provided to you by your healthcare insurer or their contractor showing up to $250 of your "Out of Pocket" medical expenses incurred through participation in that healthcare plan in Fiscal Year 2019 (July 1, 2018 through June 30, 2019) that you have paid.

Plan Holder (Name)	**Status**	**Insurance Plan (Name of Insurer)**	**Amount of Documented Expenses**
	☐ Member ☐ Spouse ☐ Dependent		
	☐ Member ☐ Spouse ☐ Dependent		
	☐ Member ☐ Spouse ☐ Dependent		
			Total: $ 0.00

You must answer all questions and provide all required information and attachments or your claim will not be processed.

I hereby certify under the penalties of perjury that I have read the plan information provided by MOSES, have provided all requested information, and that all information meets the requirements of the Massachusetts/MOSES Health and Welfare Trust Commonwealth Healthcare Mitigation Plan; that I have not requested reimbursement for payment for these same services from any other plan; and that information submitted is true and accurate to the best of my knowledge. I understand that if I make a material misrepresentation I may lose all rights to participate in this program and be liable for recovery costs of reimbursements improperly made.

Note: Send the completed reimbursement request and all necessary attachments to: **ADMINISTRATOR of Commonwealth Healthcare Mitigation Plan** **Massachusetts/MOSES Health & Welfare Trust** **PO Box 8099** **Boston, MA 02114**	**SIGNATURE:** **EMPLOYEE ID NUMBER:** (From your timesheet or check stub) **Date:**

Additional information regarding this plan is detailed on the back of this form.

Clear form

PLAN INFORMATION:

- As used in this Plan, the term "employee" means a full-time or regular part-time person employed in a MOSES Commonwealth Collective Bargaining represented title.
- Qualifying expenses are defined as those out-of-pocket medical expenses incurred while you were employed in the MOSES represented title and that have been paid, excluding premiums.
- Out-of-pocket dental expenses not covered by a Health Insurance Plan are not eligible for reimbursement. Expenses associated with a Dental Insurance Plan are not eligible.
- Only one request may be submitted per member per year. MOSES strongly advises members to wait until you reach the $250 maximum reimbursement before submitting your request.
- Reimbursement requests for Fiscal Year 2019 **must be postmarked no later than July 31, 2019**.

DEPENDENT ELIGIBILITY:

- An employee's eligible dependents are defined by their Health Insurance Plan.
- Members who are insured under a spouse's health insurance plan as a dependent are eligible for reimbursement of similar qualifying expenses.
- Proof of dependent status as defined by your Healthcare Insurer must be provided upon request.

BOARD OF TRUSTEES' STATEMENT

The Board of Trustees reserves the right to amend, modify, or discontinue all or part of this plan whenever in its judgement conditions so warrant. Only the Board of Trustees, or a designee acting on its behalf, has the authority to determine eligibility for benefits and the right to participate in this Plan.

Massachusetts/MOSES Health & Welfare Trust
Commonwealth Healthcare Mitigation Plan
Board of Trustees
PO Box 8099
Boston, MA 02114

EFFECTIVE DATES: No reimbursement for services provided before July 1, 2018 or after June 30, 2019. **Much of the documentation required for reimbursement may not be easily available after June 30, 2019 when the GIC plans reset for the next fiscal year.** Please keep copies of all submitted materials. Requests for additional forms or questions should be referred to the Administrator by mail at the address listed above or by email: HealthcareMitigation@moses-ma.org.