Los Angeles Fire & Police Pensions
TO SERVE THOSE WHO PROTECT

HEALTH INSURANCE PREMIUM REIMBURSEMENT (HIPR) CLAIM FORM

1. COVERAGE PERIOD TO BE REIMBURSED

☐ January 1 - March 31 ☐ April 1 - June 30 ☐ July 1 - September 30 ☐ October 1 - December 31

2. PENSIONER INFORMATION

Last Name:	First Name, Middle Initial:	Last 4 of SSN:
Address: (Must be the same as on file with LAFPP)	Daytime Telephone Number:	
City:	State:	Zip Code:
Email Address:		

3. HEALTH INSURANCE INFORMATION

Coverage Level (check one): ☐ Single-Party Plan ☐ 2-Party Plan ☐ Family Plan

Medicare Enrollment (check one): ☐ Parts A & B ☐ Part B Only ☐ Not Eligible

Monthly Medicare Part B Premium (if applicable): _____

ENROLLED PARTY	NAME OF HEALTH INSURANCE & MEDICAL RECORD/ID NUMBER	MONTHLY PREMIUM	# OF MONTHS	TOTAL PAID
Pensioner				
	Medicare Part D (if applicable)			
Dependent Name:				
	Medicare Part D (if applicable)			
Additional Dependents:				
			Total Health Insurance and Part D Reimbursement Request:	**$**

Does another pension/retirement plan or your current employer pay for a portion of the monthly premium?
YES _____ NO _____ If YES, what amount of the monthly premium do they pay? $_____

Comments for LAFPP Medical & Dental Benefits Section Staff:

☐ I certify that the health coverage listed was provided for myself and my qualified dependents during the period indicated, and the information and documentation provided are true and accurate. I agree that I must confirm the health plan is HIPR-eligible with LAFPP in advance of the coverage period, and understand that I must inform LAFPP of any coverage changes.

☐ I agree to inform LAFPP of any health plan premium rebate that I receive for which I have been reimbursed by LAFPP through the HIPR program and agree to submit written documentation of the rebate to LAFPP by the filing deadline of the quarter that follows receipt of the rebate. I understand that I must repay LAFPP the rebate amount less any portion of the premium paid that has not been reimbursed by LAFPP.

☐ I understand any submittal of false or fraudulent documents and/or information, including the failure to disclose refunds from cancelled plans and/or health premium plan rebates, and any other false, deceptive or otherwise improper act may result in my suspension from the HIPR program for three years and the repayment of false reimbursements, plus interest pursuant to LAFPP Board Operating Policy Section 3.10.

SIGNATURE: _____ **DATE:** _____

Los Angeles Fire & Police Pensions
TO SERVE THOSE WHO PROTECT

HIPR PROGRAM GUIDELINES

LAFPP's HIPR program is available to all pensioners who are eligible for a health subsidy and enrolled in a qualified plan. Program participants can be reimbursed up to their eligible subsidy amount for premiums covering the member and eligible dependents, or qualified survivors. Participants enrolled in Medicare Parts A&B may also file claims to be reimbursed for their basic Part B premiums.

Qualifying Health Plans – Pensioners must be enrolled as the primary subscriber or as a dependent in one of the following:

- A comprehensive major medical individual plan (must not be receiving the Federal medical premium subsidy/tax credit)
- A comprehensive major medical plan sponsored by an active employer
- A comprehensive major medical plan sponsored or subsidized by a retirement system other than LAFPP (or any other City of Los Angeles retirement system)

The health plan you choose must be state-regulated or federally qualified to coordinate benefits with Medicare. If you will be seeking reimbursement of premium costs associated with covering dependents, your dependents must be covered by the same medical insurance company and plan. Please reference the LAFPP website at lafpp.lacity.gov for more information on qualifying health plans. Dental coverage, health savings account contributions, and long-term care plans do not qualify for reimbursement. Vision plans cannot be reimbursed if billed separately.

Prior to enrolling in a new health plan, you must confirm with LAFPP's Medical and Dental Benefits Section that the intended plan will qualify for reimbursement.

Claim Requirements – A claim form must be completed and signed for each reimbursement request. Claim forms and supporting documentation will only be accepted after the coverage period has ended. You may submit reimbursement claims on a quarterly, bi-annual, or annual basis. Claims may be submitted up to one year after the last month of coverage has occurred. Please refer to the requirements in the table below.

<table>
<tr><th colspan="4">REIMBURSEMENT SCHEDULE</th></tr>
<tr><th colspan="2">Coverage Period</th><th>Claim Forms Received By</th><th>Reimbursement Provided On</th></tr>
<tr><td colspan="2">January 1 – March 31
April 1 – June 30
July 1 – September 30
October 1 – December 31</td><td>April 15
July 15
October 15
January 15</td><td>May 31
August 31
November 30
February 28</td></tr>
<tr><th colspan="4">REQUIRED DOCUMENTATION</th></tr>
<tr><th></th><th>Retiree/Qualified Survivor,
Age 55-64</th><th colspan="2">Retiree/Qualified Survivor,
Age 65+ with Medicare</th></tr>
<tr><td rowspan="2">First Claim/
New Health Plan</td><td colspan="3">Insurance Cards for all covered individuals</td></tr>
<tr><td></td><td colspan="2">Medicare Card and/or Part D Card</td></tr>
<tr><td>Proof of Premium and Payment</td><td colspan="3">One of the following:
A) Insurance billing statements; or
B) Employer paystubs; or
C) Annuity/pension statements; or
D) Verification letter from health plan provider or employer confirming each monthly premium and payment.</td></tr>
<tr><td>Supplemental Documents
(Submit annually, if applicable)</td><td>• Itemization of monthly premium.
• Qualified Survivors covering one or more dependents: Provide premium for single-party coverage.</td><td colspan="2">• Medicare Part B/D premiums.
• If your health plan covers one or more dependents: Provide premium breakdown showing the cost for single-party coverage.</td></tr>
</table>

Mail to:
Los Angeles Fire and Police Pensions
Attn: Medical and Dental Benefits Section
701 E. 3rd Street, Suite 200, Los Angeles, CA 90013

Telephone: (844) 88-LAFPP (52377) or (213) 279-3115
Email: MDB@LAFPP.com
Fax: (213) 628-7782