



Supplemental & Benefit Trusts

Medical Reimbursement Claim Form

Legal name (Last, First, MI) \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_

Provider Number \_\_\_\_\_ Gender \_\_\_\_\_ Preferred Language \_\_\_\_\_

Home Email Address \_\_\_\_\_

- Radio buttons for email preferences: 'I understand by checking this box, I am indicating I would like to receive information and updates from the Trusts via email' and 'I would like to opt out of receiving information and updates from the Trusts via email'

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

By providing my phone number, the Trusts may use automated calling technologies and/or text message me on my cellular phone on a periodic basis. The Trusts will never charge for text message alerts. Carrier message and data rates may apply to such alerts. Reply STOP to stop receiving messages, reply HELP for more information. If you would like to opt out of text messages, please check this box

ITEM REQUESTED REIMBURSEMENT

Medical Premium Reimbursement \$ \_\_\_\_\_

Monthly Proof of Medical Premium and proof of payment must be provided for each month reimbursement is requested.

- Radio button: Check here for advanced if on a family plan

Medical Out-of-Pocket Expenses \$ \_\_\_\_\_

Up to \$5000 per calendar year in 2018 and up to \$6,000 in 2019. Explanation of Benefits from your insurance company or pharmacy receipt with prescription issued must be provided for every reimbursement request.

Please DocuSign, Fax or Mail this form and supporting documents to:

- DocuSign: www.orhomecaretrust.org/reimbursement/
Fax: Oregon Homecare Worker Trust, 1-866-459-4623
Mail: Oregon Homecare Worker Trust, PO Box 6, Mukilteo, WA 98275
Phone: 1-844-507-7554 Option 3, then select Option 2

I certify that the information provided on this form is true and that I have incurred the expenses described on this form solely relating to my own medical coverage and expenses. I also certify that I have not already received reimbursement from the Supplemental Trust or any other source for any of the above-listed amounts.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_