SUBMIT COMPLETED CLAIM FORM TO:
claims@anchorbenefit.com via the secure email portal at www.anchorbenefit.com.
Fax: (407) 667-8765

QUALIFIED BENEFIT REIMBURSEMENT CLAIM FORM

PALM BEACH COUNTY FIREFIGHTERS' RETIREE INFORMATION

____
Name (Last, First, MI)

____
Social Security Number

____
Street Address

____
Email Address

____
City, State, Zip Code

____
Phone Number

REIMBURSEMENT REQUEST FOR QUALIFIED OUT-OF-POCKET EXPENSES

REMINDER: You must include proof of each expense (e.g. Explanation of Benefits, detailed receipts, etc.) Claims for employee-paid premiums deducted after-tax require a letter from the employer confirming that no pre-tax option exists. Premiums paid by an employer or deducted pre-tax through a section 125 plan are not eligible for reimbursement.

Date of Service	Service Provider or Item Purchased From (e.g. Dr. Smith, Hospital, Pharmacy, etc.)	Description of Service/Item (e.g. office visit, Hospital Care, Dental, Prescription, etc.)	Name of Qualified Individual for Whom the Expense is Incurred/Relationship	Amount You Paid
				$
				$
				$
				$
				$

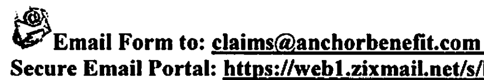
Have more expenses? Include an itemized list on a separate sheet of paper. If you want to note certain items on receipts, circle them. Do not use a highlighter. Keep copies of everything you submit.

Total Reimbursement Request	**$**

CERTIFICATION (Signature is Required)

I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of the submitted claim to Anchor Benefit Consulting is an accurate statement of my (a) unreimbursed medical/dental/vision expenses after payment by insurance (if any) and/or; (b) medical/dental/vision tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by an employer, and are not eligible for pre-tax deduction through my employer's section 125 cafeteria plan.

Signature: ______________________________ **Date:** ______________________


Email Form to: claims@anchorbenefit.com
Secure Email Portal: https://web1.zixmail.net/s/login?b=anchorbenefit

Fax Form to: (407)-667-8765

Mail to: P.O. Box 945260, Maitland, FL 32794

www.anchorbenefit.com

For questions, please call customer service at 1-(800)-845-7629 or (407)-667-8766.