SCC of SDA
SECTION 105
CLAIM FORM - 2020 Plan Year
Specialty Plan

Employee Name: _____ Final 4 Digits of SSN: XXX-XX-_____

Address: _____

City, State, Zip_____

Email address: _____ Phone Number: _____

☐ Reimburse via Check ☐ Reimburse via Direct Deposit (enter Banking Information below)

BANKING INFORMATION: Routing #: _____ Account #: _____

Reimbursement Types:

1. Counseling: 80% up to $3,600 Annually. EOB from UHC required for reimbursement.
2. Dental Implants: After the Dental Plan processes and pays the claim per the plan contract, SSC reimburses 60% of Reasonable and Customary In-Network, 50% Out of Network. Up to $3,000 Annually.
3. Alternative Care: $2,500 or 50% of treatment cost, whichever is less. Pre-approval for reimbursement must be obtained from HR before starting treatment

The undersigned participant in the Plan requests reimbursement in the amounts shown below:

REQUIRED: Participants must submit an Explanation of Benefits (EOB) from UHC or Visit Statements with Proof of Payment with this claim form to secure reimbursement from this account.

EXPENSE DETAIL:

Service Date(s)	Covered Member	Primary Account holder or dependent?	Counseling, Implants, or Alternative Care?	Cost
_____	_____	_____	_____	$ _____
_____	_____	_____	_____	$ _____
_____	_____	_____	_____	$ _____
			TOTAL:	$ _____

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Cafeteria Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ Date _____
Employee's signature

Please submit all claim forms and documentation to:
Peter C. Foy and Associates, attn: Flex Dept.
6200 Canoga Ave, Suite 325, Woodland Hills, CA 91367 or fax to (818) 703-0935
Email forms to flex@pcfoy.com
For questions contact the Reimbursement Dept. at (818) 703-8057

NO CLAIMS FOR 2020 WILL BE ACCEPTED AFTER MARCH 31, 2021