MERS® Municipal Employees' Retirement System

Alerus Retirement and Benefits
201 E. Clark St. • Albert Lea, MN 56007
866.808.7823 (option 3)
www.mersofmich.com

Health Care Savings Program Reimbursement Claim Form

Please print clearly • See attached guide for details • Retain a copy for your records

Submit Your Reimbursement Electronically

1. Upload your Reimbursement Claim Form to the Claims Management Portal in your myMERS account.
2. Download the Alerus Health Benefits app and attach your receipt using your mobile device's camera.

1. Information about you

Last name*	First name*	Social Security Number*	Phone number (with area code)*

Name of employer*

2. Reimbursement/payment election

To receive reimbursement, participant must list expenses in the table below and attach a copy of the third party receipt, bill, or a statement showing amount(s) as proof of costs incurred. This third party receipt **must** show expense that has been paid. Expenses may **not** be those covered by insurance.

Medical Expenses Date(s) Provided	**Expense** (Co-pays, Rx, Dentist, etc.)	**Provided to** (Name, relationship	**Amount**	**Total**
				$
				$
				$
				$
				$
				$
		Attach additional forms if needed	**Claim Total**	$

3. Claimant's certification and signature

1. I certify that all expenses for which reimbursement of payment is claimed by submission of this form were incurred either by me or by my dependent(s)
2. I certify that the medical expenses incurred by me or by my dependent(s) are "qualifying expenses" as defined by the Internal Revenue Code, Section 213(d). I understand that if these medical expenses are deemed not to be qualified medical expenses, I may be liable for payment of all related taxes on amounts paid by the Plan related to such unqualified expenses.
3. I certify that the medical expenses claimed have not been reimbursed or cannot be reimbursed under any other health plan coverage.
4. I take full responsibility for the accuracy and veracity of all the information I have provided. I certify I am entitled to these benefits.
5. I understand that all reimbursements are made by Direct Deposit from MERS HCSP and must go into the same account.

Signature of member*	Date (mm/dd/yyyy)*

* Required field

Step-by-Step Guide to Completing the Health Care Savings Program Reimbursement Claim Form

This form is available for download at *www.mersofmich.com*.

Please print clearly. Fields with an asterisk (*) are required fields and must be completed to submit the form accurately.

1. Information about you*

This section gathers basic information about you – your legal name, Social Security Number, phone number, and the name of the MERS employer under which this Health Care Savings Program was installed.

If you have made changes to your personal information, please be sure to update your MERS record by logging into your account at *mymers.mersofmich.com* or by completing the *Personal Information Form* (MD-001). You can download the form at *www.mersofmich.com* or call 800.767.MERS (6377) to have a form mailed to you.

2. Reimbursement/payment election

In this section, please list the details of your expenses (insurance premiums, medical expenses, etc.) in the table provided and attach a copy of the third party receipt, bill, or statement as proof of costs incurred.

For a comprehensive list of eligible Health Care Savings Program reimbursements, visit *www.mersofmich.com/hcsp* or the myMERS Member Portal.

3. Claimant's certification and signature*

Your signature certifies that you're claiming expenses that qualify, and have read and understand the terms of reimbursement.

Please sign and date the form.

Submitting this form:

Please mail completed form to:

Alerus Retirement and Benefits
201 E. Clark St.
Albert Lea, MN 56007

Questions? Please contact us at 866.808.7823 (option 3).

If you have speech or hearing difficulties and need assistance completing this form, contact the Michigan Relay Center at 800.649.3777. If you have other disabilities, contact MERS at 800.767.MERS (6377) to request special accommodations.