SCC of SDA
SECTION 105
CLAIM FORM - 2024 Plan Year
Deductible Reimbursement

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 #: _____

Single: Employee pays first $500 of $6,100 deductible. Employer will then reimburse the next $4,000 of deductible. Employee pays remaining $1,600 of deductible. Total OOPM is $7,000. Employee pays additional $300. Employer pays remaining $600 of OOPM.
EE's total OOPM is up to $2,400 and ER's total reimbursement is up to a total of $4,600.

Family: Employee pays first $1,000 of $12,200 deductible. Employer will then reimburse the next $8,000 of deductible. Employee pays remaining $3,200 of deductible. Total OOPM is $14,000. Employee pays additional$600. Employer pays remaining $1,200.
EE's total OOPM is up to $4,800 and ER's total reimbursement is up to a total of $9,200.

EE	Employee
ER	Employer
HSA	Health Savings Acct
OOPM	Out-of-Pocket Maximum

The undersigned participant in the Plan requests reimbursement.

REQUIRED: Participants must submit an Explanation of Benefits (EOB) showing Deductible and OOP Accumulators from Anthem Blue Cross with this claim form to secure reimbursement from this account. No other forms of documentations will be accepted.

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.

_____ _____
Employee's signature Date

Please submit all claim forms and documentation to:
Peter C. Foy and Associates
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 Reimbursements Dept. at (818) 703-8057

NO CLAIMS FOR 2024 WILL BE ACCEPTED AFTER MARCH 31, 2025