C R A N S T O N P E R M A N E N T F I R E F I G H T E R ' S

R E L I E F A S S O C I A T I O N

P. O. BOX 20570
CRANSTON, RHODE ISLAND 02920

MEDICAL BENEFIT WORKSHEET

NAME_____ **PHONE** _____**EMAIL**_____

MEDICAL / CLAIM $_____ **(OFFICE VISITS and CO-PAYS)**
RECEIPTS ATTACHED? YES NO (No Statements ALLOWED)
2020 CALENDER YEAR YES NO (circle)

Cosmetic/laser surgeries, Hair/Body remover/enhancement, teeth whitening, dental, chiropractic, therapies, are not covered. Procedures not covered by Insurance Companies are not covered.

PRESCRIPTIONS $ _____
PHARMACY PRINTOUT (WE DO NOT ACCEPT INDIVIDUAL RECEIPTS)
2018 CALENDER YES / NO (circle one)

Prescription medications and equipment that are not covered by Insurance Companies are not covered.

SUPPLEMENTAL / "MEDIGAP" INSURANCE PREMIUM $_____
(COPY OF MEDICARE PART A & B CARD AND SUPPLEMENTAL INSURANCE PREMIUM BILL & PROOF OF PAYMENT)

(BELOW IS FOR THE AUDIT COMMITTEE ONLY)

MEDICAL $ _____**PRESCRIPTION $** _____
PSYCHOLOGICAL $ _____ **(MAX 20%/$800)**

Audited Amounts Approved By: _____**BY:**_____

REJECTED or HOLD BY: _____**REASON**_____

DATE CONTACTED_____

Medical Claims

Dear Member,

This form must be signed and returned to the Cranston Permanent Firefighter's Relief Association with the completed beneficiary form before issuance of claim check.

I do hereby swear that all bills submitted to the Cranston Permanent Firefighter's Relief Association are my own personal medical expenses, and are not covered by any other medical coverage (e.g. Blue Cross, United Health). These expenses have not been incurred due to an occupational injury. I realize, under laws of perjury, any falsification of these documents, or non-compliance with the rules and regulations of the CPFRA (Article XV Section 1), will result in immediate expulsion from the Association, and all claims plus penalties will have to be paid at my own expense.

ATTENTION: Please contact your pharmacist to request a print-out of all your prescriptions for last year. This will help to expedite your claim.

NAME (please print)

SIGNATURE **DATE**

E-MAIL ADDRESS **(PLEASE INCLUDE FOR FUTURE CORRESPONDENCE)**

ADDRESS

CITY **STATE** **ZIP**

☐ Check this box if new address.

☐ Check this box if new e-mail address.

☐ Check this box if new beneficiary info.

Beneficiary Status

Please complete this portion of the form if you are a new member, or if any of the information here has changed. **You do not need to fill this out if there have not been any changes**. If needed, we will go by the most recent information we have on file. If you include an **e-mail address** we can send correspondences electronically, saving the Association time and money.

PLEASE PRINT

Last First MI DOB

Home Address City State ZIP

Second Address City State ZIP

Home Phone Cell Phone

Spouse's Name MI DOB

Children's Name(s) MI DOB

Beneficiary - Last First MI DOB

Address City State ZIP

Beneficiary Phone# E-Mail Address

Other Information:

Signature in full Date

Attention Member,

If you are planning to submit a medical claim for this calendar year, please observe the following rules.

1. It is very important that you submit all your medical bills to your health care provider **first** for payment, and *then* any remaining bills to the Relief Association.
2. ****<u>NO OCCUPATIONAL INJURY BILLS.</u>**** These are to be submitted to the City or to your employer.
3. Only Association members' bills are to be submitted for payment. No other family member is covered.
4. Send in all bills to the Post Office Box, or they can be dropped off at Station Four. If dropping off, please be sure the package is clearly labeled, given to a firefighter, and that the firefighter you give it to understands that it is for the Association. Please submit all bills no later than **January 31**.
5. **PHOTOCOPIES OF BILLS WILL NOT BE ACCEPTED. Only the original, UNALTERED bill or an official, UNALTERED print-out from the pharmacy with the totals for all prescriptions can be submitted.**

If you have any questions, please contact a board member as soon as possible.
A copy of Article XII, Hospitalization and Medical Expenses is printed below this notice.

Thank You,
The CPFRA Medical Claims Director

ARTICLE XII

HOSPITALIZATION AND MEDICAL EXPENSES

SECTION 1. The Association shall, during any one calendar year, pay to any active or pensioned member who has for at least one year been a member in good standing, as that term is defined in these by-laws, a sum not to exceed SIX HUNDRED ($600.00) DOLLARS, for medical bills and/or prescriptions, subject to the following terms and conditions:

a. Prior to any medical or prescription payment being made pursuant to Article XII hereof, the member seeking said payment must first exhaust all other insurance available to said member, including but not limited to any paid insurance plan offered by the City of Cranston, and any plan in which said member is enrolled either privately or through another employer.

b. In any event, payments to a member pursuant to Article XII hereof shall be payable only to the extent that those medical expenses incurred exceed the total amount payable pursuant to said member's other medical insurance.

c. Total payments to a member, including but not limited to payments for prescriptions, medical costs, psychiatric and/or mental health, shall not exceed SIX HUNDRED ($600.00) DOLLARS per member per calendar year.

d. In order to protect the Association's assets against market downturns, the Association will determine each year what percentage of the annual Medical Benefits will be paid out, based on the market value of the Association's investment account as of the close of business on December 31. The payout will be a sliding scale, as follows:

Investment Account Balance	Maximum Percentage Payout
$800,000 and above	100%
$700,000 - $800,000	70%
$500,000 - $700,000	35%
$500,000 and below	0%

The percentage applies to any and all medical benefit claims, regardless of the amount.

SECTION 2. Subject to the above limitations, the Association shall pay prescription benefits on a sliding scale:

Investment account balance $1,250,000 and below payment is 50 %.
Investment account balance $1,250,000 to $1,750,000 payout is 75%.
Investment account balance 1,750,000 and above payout is 100%.
Investment account balance as of January 1st of the new fiscal year.

All Medical claims must be submitted by February 28th for the previous year's claim. Medical claim payouts will be paid March 1st thru March 31st. All medical claims received after February 28th will be paid at a later date. If an extension of time is needed, said member should contact a Board member, for an extension and assistance with their medical claim.

SECTION 3. Subject to the above limitations, the Association shall pay TWENTY PERCENT (20%) of said member's psychological and or mental health costs, which are directly incurred by said member. Payments made pursuant to Section 3 hereof shall not, under any circumstances, exceed the sum of ONE HUNDRED TWENTY ($120.00) DOLLARS per member per year.

SECTION 4. The Association shall not make payments to members for the following:

a. Dental work of any kind;
b. Chiropractic treatment;
c. Physical Therapy treatment;
d. Any sums, which are required to be paid pursuant to contractual obligations, imposed on said member by said member's health insurance carrier(s) or by said member's employer(s).
e. Injuries which occur during the course of employment with the City of Cranston or with any other employer, or any other injury for which said member could apply for workers' compensation benefits.