CPFRA MEDICAL CLAIM FORM

Dear Member,

This form must be signed and returned to the Cranston Permanent Firefighter's Relief Association **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.

NAME_____

ADDRESS_____ **CITY**_____

STATE_____ **ZIP**_____

EMAIL_____ **PHONE**_____

SIGNATURE_____ **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. **NO OCCUPATIONAL INJURY BILLS.** These are to be submitted to the City or to your employer.

3. Only the 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.

6. **Please contact your pharmacist to request a print-out of all your prescriptions for last year.**

This will help to expedite your claim.

If you have any questions, please contact a board member as soon as possible.

Thank You,

The CPFRA Medical Claims Director

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)
2021 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.**
***Any active member enrolled in a Health Savings Account (HSA) shall be entitled to only medical claims which exceed the deductible for their particular account for the year claimed.**
***Prescription medications and equipment that are not covered by Insurance Companies are not covered.**

PRESCRIPTIONS $ _____
PHARMACY PRINTOUT (WE DO NOT ACCEPT INDIVIDUAL RECEIPTS)
2021 CALENDER YES / NO (circle one)

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 PAYOUT FOR 2021 IS $900.00
Audited Amounts Approved By: _____**BY:**_____

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

DATE CONTACTED_____

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 for medical bills, supplemental insurance premiums 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 supplemental medical insurance premiums, shall not exceed a sum, per member per calendar year, based on the market value of the Association's investment account as of the close of business on December 31. The maximum total payout shall be a sliding scale, as follows:

Investment Account Balance	Maximum Claim
$800,000 and Below	$0
$800,001 to $1,250,000	$300
$1,250,001 to $1,500,000	$475
$1,500,001 to $1,750,000	$600
$1,750,001 to $2,000,000	$700
$2,000,001 to $2,500,000	$800
$2,500,001 to $3,000,000	$900
$3,000,001 and above	$1000

SECTION 2.

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.

Subject to the above limitations and provided that said member is retired, above the age of 65 and enrolled in Medicare Part A and B, the Association shall provide reimbursement for supplemental medical insurance premiums. For purposes of this Association, Medicare Part A and B shall be considered a primary health insurance and not supplemental. With the exception of Medicare A and B, all other forms of Medicare Plans and qualified private market supplemental or "Medigap" plans shall be considered supplemental in nature. Withstanding the above, final determination as to what is and what is not qualified supplemental medical insurance shall be determined by The Board of Directors and further addressed through Medical Claims Policy and Procedure. Any denied member shall be afforded the right of appeal.

SECTION 5.

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.

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

"MEDIGAP" / SUPPLEMENTAL INSURANCE

Dear CPFRA Member,

I am writing you today to give a brief explanation of a major By-law change that may affect you. For the past 18 months, The CPFRA Board of Directors has worked tirelessly on updating our By-laws to benefit our members even further. All proposed changes were approved unanimously.

One change that may affect you as a retiree is the addition of Article XII, Section 4:

"Subject to the above limitations and provided that said member is retired, above the age of 65 and enrolled in Medicare Part A and B, the Association shall provide reimbursement for supplemental medical insurance premiums. For purposes of this Association, Medicare Part A and B shall be considered a primary health insurance and not supplemental. With the exception of Medicare A and B, all other forms of Medicare Plans and qualified private market supplemental or "Medigap" plans shall be considered supplemental in nature. Withstanding the above, final determination as to what is and what is not qualified supplemental medical insurance shall be determined by The Board of Directors and further addressed through Medical Claims Policy and Procedure. Any denied member shall be afforded the right of appeal. "

Put simply, if you are retired, over 65, enrolled in Medicare Parts A & B and pay for a supplemental or "Medigap" insurance plan, the Association will now reimburse a portion of that premium in accordance with Article 12 of our By-laws.

To receive the reimbursement, members must provide the following:

1. **A copy of your MEDICARE Card.**
2. **A copy of your Supplemental Insurance Plan / Statement, bearing the type of insurance.**
3. **Proof of payment of premium.**

This is a major change that The CPFRA Board of Directors feels as though includes more retired members of the Association who in the past may have not submitted any medical claims. In addition, retired members may find this to be an easier way to file a medical claim as opposed to traditional medical claim and or prescription claims.

If you have any questions do not hesitate to contact me, Thank you.

Jonathan Warren, President, CPFRA.
(401) 585 – 4783 jwarren1363c@gmail.com

CPFRA BENEFICIARY FORM

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 _____

1ST ADDRESS _____

CITY _____ STATE _____ ZIP _____

2ND ADDRESS _____

CITY ` _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SPOUSE'S NAME _____

MI _____ DOB _____

CHILDREN'S NAME (S) _____

MI _____ DOB _____

_____

BENEFICIARY- LAST _____ F IRST _____ MI _____ DOB _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE# _____ EMAIL _____

OTHER INFORMATION _____

_____

SIGNATURE: _____ DATE _____