Administered By:
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
Phone: (800) 828-0223
Email: santamonicacity@bpabenefits.com

Santa Monica City Employees Coalition Benefit Trust

SMCECBT

PARTICIPANT DATA FORM

Plan Participant Name: _____

Address: _____

_____

Daytime Phone #: _____ E-mail Address: _____

Date of Birth: _____ Social Security Number: _____

Participating Employer / Bargaining Unit: _____

Date of Employment (hire date) with the City of Santa Monica: _____

Anticipated Date of Retirement or Actual Date if already Retired: _____

Spouse: _____

Date of Birth: _____ Date of Marriage: _____

Dependent Information:

Name: _____ Relationship: _____

Date of Birth: _____

Name: _____ Relationship: _____

Date of Birth: _____

Name: _____ Relationship: _____

Date of Birth: _____

I certify under penalty of perjury that the foregoing is true and correct. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided.

_____ _____

Participant's Signature Date

The below questionnaire must be completed if you are not submitting any claims for reimbursement.

I am not submitting claims for reimbursement of insurance premiums at this time for the following reason(s) – select all that apply:

- ☐ I have no out-of-pocket expenses for medical, dental, vision, or long-term care insurance premiums at this time
- ☐ I have no out-of-pocket expenses for Medicare Part A, B or D premiums at this time
- ☐ I have no out-of-pocket expenses for Medicare supplemental insurance premiums or Medigap premiums at this time
- ☐ All of my insurance premiums are paid with pre-tax income at this time
- ☐ I am ineligible for reimbursement benefits due to return to work at the City of Santa Monica
- ☐ My employer or my spouse's employer pays all insurance premiums
- ☐ Retiree is deceased and I did not know that the Surviving Spouse's insurance premiums are reimbursable
- ☐ I do not know how to obtain the required documentation to submit a claim
- ☐ Other: _____

Do not hesitate to contact the Santa Monica City Employees Coalition Benefit Trust Administrative Office at 800 828-0223 if you incur a change in your status.