FUJIFILM

RETIREE MEDICAL REIMBURSEMENT ACCOUNT (MRA)
CLAIM FORM

INSTRUCTIONS

- COMPLETE ALL SECTIONS INCLUDING INSURANCE INFORMATION IN SECTION B
- SUBMIT MEDICAL, DENTAL AND VISION EXPENSES TO APPROPRIATE INSURANCE CARRIER
- ATTACH EXPLANATION OF BENEFITS (EOB) FROM THE INSURANCE COMPANY WITH AN ITEMIZED STATEMENT FROM THE PROVIDER INDICATING PROOF OF PAYMENT
- ITEMIZED BILLS SHOULD INCLUDE THE FOLLOWING:
  - PROVIDER NAME AND ADDRESS ■ PATIENT NAME ■ ITEMIZED CHARGES ■ DATE OF SERVICE ■ TYPE OF SERVICE
- CANCELLED CHECKS (ALONE), NON-ITEMIZED RECEIPTS, AND BALANCE DUE BILLS ARE **NOT ACCEPTABLE** PROOF OF PAYMENT
- COPAY RECEIPTS MUST INCLUDE THE NAME, ADDRESS AND PHONE NUMBER OF THE PROVIDER OF SERVICE
- IF YOU HAVE ANY QUESTIONS, PLEASE CALL TOLL FREE: (866) 444-FUJI (3854)
- MAIL COMPLETED FORM ALONG WITH APPROPRIATE DOCUMENTATION TO:

ASSOCIATED ADMINISTRATORS, LLC
P.O. BOX 1063
SPARKS, MD 21152-1063

A. RETIREE INFORMATION

SOCIAL SECURITY NUMBER	PHONE NUMBER	
LAST NAME	FIRST NAME	M.I.
ADDRESS	CITY STATE	ZIP CODE

B. HEALTH CARE EXPENSES

PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE:

MEDICARE COVERAGE?	☐ YES*	☐ NO
MEDICARE SUPPLEMENTAL?	☐ YES*	☐ NO
OTHER INSURANCE?	☐ YES*	☐ NO
DENTAL COVERAGE?	☐ YES*	☐ NO
VISION COVERAGE?	☐ YES*	☐ NO
PRESCRIPTION DRUG?	☐ YES*	☐ NO

*IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.

PATIENT NAME	PROVIDER (I.E. DOCTOR NAME/ PHARMACY NAME)	DATE(S) OF SERVICE	TOTAL CHARGE A.	AMOUNT PAID BY OTHER SOURCES B.	AMOUNT TO BE REIMBURSED (A - B = C)
	TOTAL REIMBURSEMENT REQUEST: $_____				

C. CERTIFICATION

The above is a true and accurate statement of non-reimbursed health expenses paid by me for the date(s) indicated. These expenses were incurred while I was covered under the FUJIFILM Retiree Medical Reimbursement Account. I have submitted any health expenses covered by Medicare and/or other insurance to those plans, but payment has been denied in full or in part. I have included an Explanation of Benefits from my insurance company and payment receipts from my service provider(s) for all expenses paid by me.

RETIREE SIGNATURE ***(Required)***	DATE

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Retiree Medical Reimbursement Account Administration

INSTRUCTIONS FOR RETIREE MEDICAL REIMBURSEMENT ACCOUNTS

- Only retirees participating in the Plan may submit a reimbursement form.
- Reimbursements may only be made for eligible expenses incurred after the MRA begin date.
- The account is good for your lifetime, or until the balance is depleted.
- Complete the information on the reimbursement form for each amount claimed and including a total.
- If you receive reimbursement for expenses, you may not claim these expenses for income tax purposes.
- **You must sign the form,** thereby swearing that you have not and will not submit these expenses for reimbursement from another plan.
- Submit your form and documentation to FUJIFILM MRA Administration, P.O. Box 1063, Sparks, MD 21152-1063, or by fax to 410-683-7774.
- **Please do not highlight any portion of your claim.**
- Documentation must be invoices or other written statements from the third parties that provided the services.
- **The documentation must include the provider's name and address, the date of service, the amount charged for the service and a brief description of the service.**
- **For services for which you have insurance coverage, you must submit the Explanation of Benefits (EOB) from your insurance company.**
- In general, the types of expenses for medical services that can be reimbursed by the Plan are the same types of expenses that the Internal Revenue Service would allow for the health expense deduction under Internal Revenue Code Section 213(d). Further information can be found by obtaining IRS Publication 502 by calling 1-800-829-3676 or viewing www.irs.gov/formspubs/.
- Over-the-counter (OTC) drugs - Please be certain that the full name of the OTC drug is on your receipt. This information is necessary in order for us to determine whether or not it is eligible for reimbursement. Over-the-counter drugs and medicines are not eligible for reimbursement from your MRA unless you obtain a prescription from your physician for the drug or medicine.
- Orthodontics cannot be reimbursed for the entire amount. Claims for the initial down payments usually associated with the appliances and monthly payments will be accepted.

Associated Administrators, LLC, P.O. Box 1063, Sparks, MD 21152-1063
Telephone: (866) 444-FUJI (3854)
www.associated-admin.com