Health Insurance Assistance Claim Form

Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, New York 11716-2513
(631) 319-4099 www.scmebf.org

FOR ADMINISTRATIVE USE ONLY

MEMBER: LAST FIRST	BENEFIT FUND # (starts with BF00) BF00
MAILING ADDRESS	HOME PHONE
CITY STATE ZIP	CELL PHONE
EMAIL ADDRESS	OFFICE PHONE
JOB TITLE	DEPARTMENT
HIRE DATE / TERM DATE (if applicable) / LEAVE OF ABSENCE (WITHOUT PAY) START & END DATES FOR YEAR SUBMITTED (if applicable)	
PAYROLL DEPARTMENT CONTACT NAME	PAYROLL DEPARTMENT CONTACT PHONE #

Requirements

This Claim Form along with the necessary documentation **must be submitted no earlier than June 1st** & no later than May 31st of the calendar year following the year in which the premium cost-share was incurred (e.g., for 2024 premium cost-share, the **claim must be received by the Fund after June 1, 2025 & no later than May 31, 2026**).

Please fill out the information requested above and **attach a copy of the member's end of the year pay stub** reflecting the amount of the health plan premium cost share deducted, which can be printed from your employee portal or requested from your payroll department if you do not have access to a County computer.

If you did not work a complete year you must provide your hire date, termination date or leave of absence dates (without pay) on the form above. Please provide documentation of termination date or leave of absence (without pay) dates (including multiple leave of absence date ranges). If you did not work a complete year your reimbursement will be prorated. You must provide your last paystub just prior to your termination date for the Fund to be able to process your claim.

Members must submit the ORIGINAL of this form with the necessary information and documentation for this claim to be processed.

I certify the above information is correct.

MEMBER SIGNATURE **DATE**

For Administrative Use Only

Overview

The Health Care Assistance benefit is used to assist active members who are currently paying more than 2.4% of their annual base salary towards one of the County Health Plans' "premium" cost share. The County minimum cost share is currently $1500, therefore, if a member's annual base salary is less than $62,500 for 2024, they would be eligible for this benefit. Members must be enrolled in either the EMHP or a County-offered HMO **and** paying the cost share to be eligible for this benefit.

The Benefit will be calculated by subtracting 2.4% of your annual base salary from $1,500. This equates to the amount over 2.4% a member pays into their County Health Care plan. Then, that number is multiplied by 0.15 (15%) to calculate the amount the Benefit Fund will reimburse the member (the benefit). If you did not work a complete year your, then reimbursement will be prorated accordingly.

The Benefit will be calculated and determined by the Benefit Fund.

Due to the complicated nature of this benefit payment may take several months.

We appreciate your patience.