Medicare Supplemental Trust Fund Rules/Guidelines
City of Grand Rapids - bargained by Fire
(Return this page to the City of Grand Rapids)

1. Retiree MUST be 65 years of age or older.

2. Supplemental health coverage MUST be comparable to the City of Grand Rapids Health Plan and the City must receive proof (i.e. table of contents).

3. The attached Medicare Supplemental Trust Fund application must be completed and forwarded to the city along with the invoice from your insurance carrier. **No application will be accepted without an invoice from your insurance carrier attached.** This must be done before you are eligible for the Benefit.

4. According to the Medicare Supplemental Trust Fund Ordinance, **the City must pay the insurance company directly. Do not pay the invoice yourself. You must continue to send an invoice when the premium needs to be paid.** Any invoices received less than seven days from its due date will not be processed for payment by the City.

5. The city will only issue one check to one insurance company.

6. Premiums will be paid on a quarterly basis by the City. If a monthly invoice is submitted, the City will use it to calculate your premium reimbursement for the current quarterly period based on a calendar year.

7. If your insurance carrier is not listed in the City's Accounting System (to find out you may call Insurance Services at (616-456-3300) you and/or your beneficiary will be responsible to contact your private insurance carrier for completion of the required vendor registration process.

It is critical you and/or your beneficiary allow the City sufficient time for invoice processing and new vendor set-up. Please apply for your application for the Medicare Supplemental Trust Fund benefit and return it to the City of Grand Rapids Human Resource Department as soon as possible.

Items to Forward to the Citiy's Human Resources Department - Checklist...

☐ I have attached the Medicare Supplemental Trust Fund Rules/Guidelines with my signature and date.

☐ I have attached the Medicare Supplemental Trust Fund Reimbursement Application complete with signatures.

☐ I have attached the invoice from my insurance carrier.

☐ I have check to see if the City has my insurance carrier listed in its Accounting System.

I have read and understand the information above and agree to comply with the requirements as stated.

Signature: _____ **Date:** _____

Effective: 4/16

ADDENDUM "B-2"