Abortion Travel Reimbursement Form

SAG·AFTRA HEALTH PLAN

Instructions

The SAG-AFTRA Health Plan (the Plan) covers reimbursement of reasonable travel expenses to receive abortion services covered by the Plan only if you are a Participant, covered Dependent spouse, or a covered Dependent child (in case of emergency abortion only), and you are unable to obtain abortion services without traveling because you reside or temporarily work in a state where abortion is illegal.

What is Covered:

- Travel costs to state of residence or nearest state where abortion is legal.
- Transportation costs include coach/economy airfare, subway, train, ride share, bus, taxi, or other public transportation at 100%. For personal vehicle, reimburses using regular mileage rate. Reimbursement for rental car up to $65/day.
- Hotel Allowance not to exceed $300/night total, not per person, meals not included. Includes night prior to and during the course of receiving the specified services. Not available if travel is to state of residence.
- A travel companion.

Reimbursement will not be issued until the claim for the service is received by the Plan. Patient incurs costs and then submits to the Plan for reimbursement. Taxable income (if above IRS limits) is reported on Form W-2.

WHAT TO SUBMIT:

The completed form along with copies of receipts for all paid travel expenses eligible for reimbursement

HOW TO SUBMIT:

Log in to your Benefits Manager to submit your form and receipts online at: sagaftraplans.org/login

Or

Email your completed form and receipts to: psd@sagaftraplans.org

Participant

LAST NAME	FIRST NAME	MIDDLE NAME	PHONE NUMBER ( )	PARTICIPANT ID (HCID)

Patient Information

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH

PATIENT'S STATUS WITH SAHP: Participant ☐ Spouse ☐ Child ☐	PROVIDER OF SERVICE	DATE OF SERVICE

Travel Expense Information (Copies of receipts must be included)

Type	Description	Miles Traveled	Charges

I certify under penalty of perjury that to the best of my knowledge all information provided on this document is true, correct and complete. I acknowledge that it is fraudulent to knowingly fill out this form with any information that is false.

SIGNATURE OF PATIENT _____ DATE _____

Questions? Please call us at (800) 777-4013.