emeriti RETIREMENT HEALTH

Automatic Premium Reimbursement

IC02

Skip the form!

Log into your Emeriti RHSP online account at **MyEmeritiHealth.org** to set up your recurring eligible premium reimbursements online.
To submit this paper form, follow instructions provided below and send to: **Emeriti RHSP, PO Box 4391, Clinton, IA 52733-4391.**

1 Participant Account and Contact Information (Please fill out your information below)

If you are claims-eligible under more than one benefits account, enter the account number of the account from which you want your automatic reimbursement. Otherwise, your automatic reimbursement will be taken from the account with the applicable coverage type and the earliest claims-eligibility date. **(All information in this section is required to process your automatic premium reimbursement request.)**

Account Number or SSN: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Address: _____ Is this a new address?: ☐

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

2 Automatic Premium Reimbursement Information

This is a: ☐ **NEW** Request
☐ **CHANGE** to existing reimbursement

Amount of each reimbursement:

NEW AMOUNT: _____

OLD AMOUNT: (if this is a change) _____

Frequency: ☐ Monthly ☐ Quarterly

Begin Date (mm/dd/yyyy)[1]:
1 - Will be the 1st of the Month. _____

End Date (mm/dd/yyyy)[2]: _____
2 - If you do not enter an end date, your reimbursement will continue until you make a change or 12 months after the initial reimbursement.

☐ Please make my first reimbursement retroactive to my requested begin date, if the begin date is in the past, or if this request is not received in time.

Is this policy in your name?
☐ Yes
☐ No

If reimbursement is for a policy not in your name (such as your spouse's), please list his/her name, Social Security, number or policy number, and date of birth.

Name _____ SSN or Policy Number _____ Date of Birth _____

3 Direct Deposit Enrollment (Recommended)

Direct deposit is faster and more convenient than waiting to receive paper check reimbursements in the mail. Information you provide below will super-sede any previous direct deposit enrollment on file. A voided check is not required.

This is a: ☐ New Request
☐ Use direct deposit already on file

Account Type: ☐ Checking
☐ Savings

Name of Bank or Credit Union: _____

Account Number _____ 9 Digit Routing/Transit Number _____

4 Required Expense Supporting Documentation

Please provide copies of documentation for the premiums or expenses that are eligible for reimbursement. Please ensure that your documentation contains the following items:

1. **Name of policy holder or covered individual (employee, spouse, dependent)**
2. **Date of policy period**
3. **Name of the insurance carrier**
4. **Amount of premium**

Additionally, please also:

- Send photocopies of your form and documentation, keep the original for your records
- Ensure documentation is legible. Please do not use a highlighter.
- Note that cancelled checks, balance forward statements and credit card receipts do not contain all of the required information and are NOT acceptable.

5 Certifications (Read before submitting)

By submitting this form:

1. You agree to the Terms and Conditions of your employer's Emeriti RHSP plan, as amended from time to time, which can be found in the Summary Plan Description. To get a current copy of the Summary Plan Description, log into your Emeriti RHSP portal account at **MyEmeritiHealth.org** and click **Resources** on the menu bar or contact our Customer Care Center at 866-363-7484.
2. You authorize the Plan to disburse funds from your benefits account as requested. For direct deposits: you authorize and request that the Plan electronically deposit a monthly reimbursement for your insurance premium(s) to the financial institution on file. This authorization is not an assignment of your right to receive payment and revokes all prior payment direction notifications. You understand funds availability is subject to your banking institution's policies and procedures. You understand the authorization(s) on this form will remain in effect until your benefits account is depleted or until cancelled by written notice from you or your power of attorney.
3. You understand that it is ultimately your responsibility to notify the Plan if your premium amount changes. You agree to hold your employer, the Plan, and all Plan service providers harmless for any damages that may occur from incorrectly completing this form. You also certify that (1) the premium amount submitted is the accurate amount of your cost of qualified insurance premiums; and (2) all persons covered under the insurance policy meet the Plan requirements and are qualified or coverage under the Emeriti RHSP Plan. You also acknowledge and agree that any claim submitted fraudulently could result in your termination from the Plan and/or other legal action.

Questions? 1-866-EMERITI (1-866-363-7484)