RECURRING INDIVIDUAL PREMIUM REIMBURSEMENT REQUEST

(Former) Employer Name:	From what initial date would you like reimbursements of your premium(s) to start?
Plan Year:	

Retiree/Employee Information

Retiree/Employee Name:	Last 4 of Social Security #:
Home Address:	Retirement Date:
Email:	Phone:

Individual Policy Information – This is required information and must be filled out completely to process your request.

Name of Insured Person:	
Name of Insurance Carrier:	
Type of Coverage:	
Plan Year/Policy Start Date:	Plan Year/Policy End Date*:
Total Monthly Individual Premium Amount Requested:	

Employee Acknowledgement of Recurring Premium Reimbursement Request

Please initial next to each line to indicate you acknowledge the terms of this recurring premium reimbursement request.

_____ I understand that insurance premium claims are considered to be incurred on the first day of the month of coverage and that I cannot be reimbursed for expenses prior to that, regardless of the date the insurance bill was paid.

_____ I understand that claims are batched on the first Thursday after the 1st day of each month and reimbursement is sent the following week on Friday.

_____ I have attached a proof of my insurance coverage that includes the type of coverage, premium amount and contract period. Acceptable documents include a letter from the insurance company that includes the above information, a copy of a contract renewal letter or a letter from the former employer sponsoring the plan.

_____ *I understand that I will be set up for recurring reimbursement until the plan year/policy end date**,** when the rates will most likely change. I understand that I will need to complete a new form and send proof of insurance coverage when my insurance premiums change at the end of the plan year/contract or for any other reason.

_____ I understand that I am required to have direct deposit set up with TASC to receive claim reimbursements.

_____ In the event that my coverage is terminated for any reason, I am required to inform TASC within five (5) days of the termination so that future reimbursements can be stopped.

_____ I certify the above information is correct and the expenses claimed will incur on a regular basis by me or my eligible dependents after my effective date of coverage in my employer's Retiree FHRA Plan or Individual Premium Reimbursement Account. I certify these expenses are not eligible for reimbursement under any other plan, and comply with the requirements of this plan. I have not and will not claim these expenses on my personal income tax return and I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

EMPLOYEE CERTIFICATION OF RECURRING EXPENSES AND CLAIMS FOR REIMBURSEMENT

Employee Signature: _____ **Date:** _____

Submit completed form to:

Claims: claims@tasconline.com I toll-free fax 866-450-1480 I TASC I P.O. Box 7213 I Madison, WI 53707-7213

Service: svchelp@tasconline.com I toll-free 866-678-8322

DIRECT DEPOSIT AUTHORIZATION

I hereby authorize TASC to initiate deposit of my medical expense reimbursements to the bank account indicated below and, if necessary, debit entries and adjustments for any credit entries made in error to my account.

Please attach a copy of a voided check if you are electing to have reimbursement sent to a checking account.

****If you are electing to use your savings account please contact your bank for the Transit ABA Routing Number.***

If you are re-enrolling during Open Enrollment and are already signed up for direct deposit, you do not have to complete this form. We will continue to deposit reimbursements to the bank account on record.

This account is (Please check one of the following options)

New_____ Change_____ Cancel_____ Name of Bank: _____

_____ Transit ABA Routing Number

_____ Account Number

_____ Account Type (Checking or Savings*)

Attach Voided Check OR Savings Deposit Slip HERE

Bobby Brady
123 Main Street
Anywhere, USA 55439

3448
7-1-945

Date _____

Pay to the Order of _____ ☐

_____ *Dollars*

For _____ _____

⑆091000019⑆ 356489589⑈ 3448

(Routing Number) (Account Number)

Employer Name: _____ ❑ **Address Change**

Employee Name: _____ **Last 4 of SSN:** _____

Home Address: _____

_____

Email Address: _____ **Telephone:** _____

_____ Signature

_____ Date

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