Automatic Premium Reimbursement

Use this form to set up a recurring reimbursement for your eligible premiums

HRAveba

HV02 7/17 PRC

Claims-eligible participants who are actively-employed and receiving monthly employer contributions must have a minimum account balance of $2,000 to begin/renew an automatic premium reimbursement.

Skip this form! Log in at **hraveba.org** and submit your request online.

Submit paper forms to: claims@hraveba.org | HRA VEBA Plan, PO Box 80587, Seattle, WA 98108 | 206-577-3020 fax

Make sure your documentation has everything we need!

The documentation you submit needs to contain all four of the following:

1. Name of covered individual(s);
2. Coverage period or effective date;
3. Name of insurance carrier; and
4. Premium amount.

Common forms of documentation include your statement of insurance, open enrollment notice, or premium billing statement. **If you are requesting reimbursement for tax-qualified long-term care insurance premiums**, be sure to include a copy of your policy's Declarations page. The Declarations page usually contains confirmation that the policy is tax-qualified.

Is my premium eligible?

The below list of qualified premiums is not a complete list, but it does contain many examples of the types of premiums eligible for reimbursement.

- Medical*
- Dental
- Vision
- Long-term care (tax-qualified; subject to IRS limits)
- Medicare
- Medicare supplement plans
- TRICARE premiums (medical and dental plans)

** Includes marketplace exchange premiums that **are not or will not be** subsidized by the premium tax credit.*

As a reminder, premiums are not eligible for reimbursement if they are:

1. Paid by an employer;
2. Deducted pre-tax through a Section 125 cafeteria plan;
3. Eligible for pre-tax deduction from your (the participant's) paycheck through your employer's Section 125 cafeteria plan; or
4. Subsidized by the premium tax credit.

What should I do next?

- When your premium amount(s) change or stop, it is your responsibility to notify us to adjust or cancel your automatic premium reimbursement. Failure to update this information may result in your reimbursement(s) being cancelled and/or excess reimbursement amounts being reported as taxable income.
- Be sure to notify us if your direct deposit information or mailing address changes.

Go Green! Sign up for **e-communication** and avoid the paper clutter. Make your election online. Log in at **HRAveba.org** and click **My Profile** to update your **Account Preferences.**

Complete Automatic Premium Reimbursement form on reverse ▶▶

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1 PARTICIPANT ACCOUNT AND CONTACT INFORMATION

Clear Form

If you are claims-eligible under more than one participant account, enter the participant account number of the account from which you want your automatic reimbursement. Otherwise, your automatic reimbursement will be taken from the account with 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 mm / dd / yyyy _____

LAST NAME _____ FIRST NAME _____ M.I. _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

AREA CODE and PHONE NUMBER _____ EMAIL ADDRESS (use home or personal email address) _____

GO GREEN! Sign up for **e-communication** and avoid the paper clutter. Make your election online. Log in at **HRAveba.org** and click **My Profile** to update your **Account Preferences**.

IMPORTANT: Have you previously separated or retired from the employer that made or is making contributions to this account?

☐ YES
☐ NO

DATE OF SEPARATION or RETIREMENT mm / dd / yyyy _____ EMPLOYER NAME _____

2 CERTIFICATIONS: READ BEFORE SUBMITTING

By completing and submitting this form, you agree to the **Terms and Conditions**, as amended from time to time, which can be found in the **Plan Summary**. To get a current copy of the Plan Summary, log in at **HRAveba.org** and click **Resources** on the menu bar or contact our Customer Care Center at customercare@hraveba.org or 1-888-659-8828.

The following certification applies only to major medical premiums. It does not apply to dental, vision, and tax-qualified long-term care premiums:

- Any major medical premium was **either** (a) for an employer-sponsored group health plan (for coverage provided through an employer) and not for individual market coverage, **or** (2) incurred while you were separated or retired (not employed or re-employed) with the employer that contributed funds to your account.

3 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 mm / yyyy: _____

END mm / yyyy: *(optional*)* _____

*If you do not enter an end date, your reimbursement will continue until you make a change or your account runs out.

Due date of first reimbursement:
(To occur on time, request must be received at least 10 days prior to due date)

☐ 1st or ☐ 15th day of the month

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

Is the 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 _____

4 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 supersede any previous direct deposit enrollment on file. A voided check is not required.

☐ New request
☐ Use direct deposit already on file

NAME OF BANK OR CREDIT UNION _____ ☐ Checking ☐ Savings

9-DIGIT ROUTING NUMBER (see sample check) _____ ACCOUNT NUMBER (do not include check number) _____