VIA BENEFITS™

<Barcode>

Account ID: <XXXXXXXXXX>

<Plan Name>

# Recurring Premium Reimbursement Request Form

Exclusively for the account of:
<First Name> <Last Name>
<Address Line 1>
<Address Line 2>
<City>, <State> <ZIP Code>

**Save Time and Money! Go Online to correct personal information or call Via Benefits.**

**My.ViaBenefits.com/Funds**

Mail to:
PO Box 981156
El Paso, TX 79998-2256

Fax to:
844-930-0236
Total pages:

Phone number:
855-801-9759

## What I Need To Do:

- ☐ Verify account holder information
- ☐ Complete reimbursement form
- ☐ Prepare supporting documentation
- ☐ Read Certification
- ☐ Sign and date form
- ☐ Mail or fax your completed form and supporting documentation

**Your supporting documentation must contain these five items:**

- ☐ Covered participant (e.g., John Doe)
- ☐ Premium type (e.g., medical)
- ☐ Date of service (e.g., 01/01/XXXX through 12/31/XXXX)
- ☐ Monthly amount (e.g., $XXX.XX)
- ☐ Proof of premium (e.g., AARP)

Complete

| Action *(New)* | Covered Participant *(John Doe)* | Relationship *(Self, Spouse)* | Premium Type *(Medical)* | Start Date *(01/01/XXXX)* | End Date *(12/31/XXXX)* | Reimbursement *($XXX.XX)* |
|---|---|---|---|---|---|---|
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## Certification:

By signing below, I certify that the information provided on this Recurring Premium Reimbursement Request Form is correct and that the premiums for which I am requesting or for which I am providing validation: were incurred for premiums for the covered participant while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement. Upon receiving notice of a change in premium or a cancellation of coverage, I will notify Via Benefits within a suitable time period.

Sign

Account Holder Signature

Date

<PayFlex Member Number>

<YYMMDD> <employerID> 921002-180206-Recurring Premium Form

## What I Need To Know:

- Who is the account holder?
- How to fill out premium reimbursement requirements?
- What is needed on your premium reimbursement documentation?

***Fast. Safe. Secure.***

**Submit Reimbursement Requests and enroll in Direct Deposit Online**

*The fastest, safest and most secure way to be processed and reimbursed.*

**Guide to Recurring Premium Reimbursement Requests**

This form is an option available to those who do not have Automatic Premium Reimbursement available through their insurance company. Submit one Recurring Premium Reimbursement Request Form at the beginning of the year to set up recurring reimbursement for the following twelve months. There will be no need to file a reimbursement request until the following year. Premiums must be a fixed monthly amount for a set period of time. Recurring premium requests must be resubmitted each calendar year.

**Who is the account holder?**
The account holder is usually the retiree or spouse.

**How to fill out the premium reimbursement requirements?**
Complete a line for each type of premium reimbursement requested.

**Action:** A Recurring Premium Reimbursement Request Form must be submitted each time you have a new policy, at the first of a new year, when a change in your premium occurs or if a policy ends for any reason during the calendar year. Enter: “New” for New Policy, “Change” for Premium Change or “End” for End of Policy.

**Covered Participant:** Name of the covered participant (e.g., John Doe).

**Relationship:** Relationship to the account holder (e.g., self, spouse).

**Premium Type:** (e.g., medical) Refer to your eligible expenses.

**Start Date:** This is usually 01/01/XXXX of each new year or the effective date of the coverage period, such as when a participant becomes eligible.

**End date:** This is usually 12/31/XXXX, but may end earlier on a covered participant.

**Reimbursement:** This amount must match the amount on the supporting document.

**Certification:** Carefully read the certification requirements then sign and date.

**What is needed on your premium reimbursement documentation?**
All premium reimbursement requests require third party documentation showing each item below:

- Covered participant’s name (e.g., John Doe)
- Premium type (e.g., medical)
- Date of service (e.g., 01/01/XXXX through 12/31/XXXX)
- Monthly amount (e.g., $XXX.XX)
- Proof of premium (e.g., insurance company)

For Medicare Part B premiums deducted from your Social Security check, use a copy of the Social Security Benefit Award/Proof of Income Letter issued by the Social Security Administration (SSA) each year, usually during the month of October or November, as your third party documentation. **Watch for this document to arrive in the mail.**

For missing documents you can request a Benefit Award/Proof of Income Letter by contacting the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) or www.ssa.gov, or contact your insurance company and request a document that contains the five items listed above.