

Recurring Premium Reimbursement

OneExchange™

from Towers Watson

Mail to: P.O. Box 2396 Omaha, NE 68103-2396

Fax to: 1-855-321-2605

① Employer Name

Total Pages

Account Holder Name – Last

First

Middle

Social Security Number

Zip Code

② Action Relationship Premium Type Start Date End Date Monthly Amount

Action	Relationship	Premium Type	Start Date	End Date	Monthly Amount
New	Spouse	Medicare Part B	Jan 2014	Dec 2014	\$104.90 (example)

③ Certification

By signing below, I certify that the information provided on this reimbursement request form is correct and that the expenses for which I am requesting or for which I am providing validation, were incurred for premiums for the covered participant 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 OneExchange of the change within a suitable time period.

Account Holder Signature

Date

④ Your reimbursement will NOT BE APPROVED without the correct supporting documentation submitted with this request form. See the documentation instructions on the reverse side of this form for more information. Please see your Summary Plan Description (SPD) regarding the deadline for requesting reimbursements.

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Guide to Requesting Recurring Premium Reimbursement

Recurring Premium Reimbursement is an option available to those who do not have Automatic Reimbursement available on a policy.

This form allows you to request recurring reimbursements of your health care premiums for the rest of the year.

Premiums must be a *fixed monthly amount* for a set period of time and not have Automatic Reimbursement available. Recurring Premium requests must be resubmitted each calendar year.

① **Account Holder Information:** The account holder is usually the retiree or the surviving spouse.

② **Reimbursement Request Information:** This section must be filled out with a line for each premium you are requesting reimbursement.

Action: A request 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 Policy, Premium Change, or End of Policy.

Relationship: Include the relationship between the account holder and the person requesting the premium reimbursement (e.g. self).

Premium Type: Medicare Part B, Medicare Part C (Advantage), Medicare Part D, Medicare Supplement (Medigap), Dental, Vision Prescription.

Start Date: This is usually January 1st, yet can be later, depending on when the covered participant is Medicare-eligible or the effective date of the coverage period.

End Date: This is usually December 31st, yet could be earlier for a policy change or the death of a covered participant.

Monthly Amount: Monthly amount you are requesting must match the amount on the supporting document.

③ **Certification Requirement:** Carefully read the certification requirements before signing.

④ **Documenting Your Premium Request:** All premium requests require third party documentation showing (*check all as you complete each item*):

- Covered participant's name (John Doe)
- Name of the provider (Medicare)
- Date of coverage (Jan through Dec)
- Description of coverage (Part B)
- Premium amount (e.g. \$104.50)

For Medicare premiums deducted from your Social Security check, provide your "Proof of Income" letter from the Social Security Administration, sometimes called a budget, benefits, or proof of award letter.

For lost documents you can request a "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 carrier and request a document that contains the five items listed above.