Systematic Premium Reimbursement Form

Montana VEBA HRA Third-Party Administrator – Rehn & Associates
PO Box 5433 | Spokane, WA 99205
Phone: (800) 872-8979 | Fax: (509) 535-7883
Email: Montana@rehnonline.com

Personal Information

Last Name | **First Name** | **Participant Account No. or SSN**

Mailing Address ☐ Check here if new | **City** | **State** | **Zip**

Email Address ☐ Check here if new | ( ) **Phone Number**

Systematic Premiums Reimbursement Instructions

You must attach documentation which includes the following: (1) name of covered individuals; (2) premium amount; (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. **NOTE:** Premiums paid by an employer or premiums that are or could be deducted pre-tax through a Section 125 Cafeteria Plan are not eligible for reimbursement.

This is a (check one): ☐ New Reimbursement ☐ Change to existing reimbursement

Date first reimbursement should be received: _____ ☐ Check this box if you wish to receive reimbursement retroactive to this date

Effective date of insurance coverage change: _____

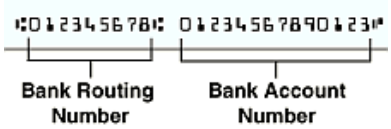
Amount of Reimbursement: _____

Frequency (check one): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Is policy in your name? ☐ Yes ☐ No*

* If no, please list the name and SSN of the policy holder: _____

Direct Deposit Information



Account: ☐ Checking ☐ Savings

Financial Institution: _____

Routing Number: _____

Account Number: _____

Authorized Signature

I (participant) hereby authorize the Third-Party Administrator (TPA) to disburse funds from my participant account as provided for in this form. I understand this systematic premium reimbursement authorization will remain in effect until my account is depleted or cancelled by written notice from me or my power of attorney. I understand that it is ultimately my responsibility to notify the TPA if my premium amount changes. I hereby agree to hold my employer, the TPA and the Montana VEBA HRA Plan harmless for any damages that may occur from following the instructions on this form. I hereby certify that the fore-going statements are true and correct and the premium amount submitted is the accurate amount of my cost of qualified insurance premiums.

This paragraph applies only if you completed the direct deposit section above: I hereby authorize and request the TPA to electronically deposit a monthly reimbursement for my insurance premiums to the financial institution designated above. This authorization is not an assignment of my rights to receive payment and revokes all prior payment direction notifications. I understand this authorization will remain in effect until my account is depleted or cancelled by written notice from me or my power of attorney.

Participant Signature | **Date**

IMPORTANT REMINDERS:

- Attach the required documentation as described above
- It is your responsibility to keep the TPA updated if your premium amount changes
- Please include your Account Number or SSN when communicating with the TPA
- Long-term care premium reimbursements must be for tax-qualified long-term care coverage and is subject to annual IRS limits.