Recurring Premium Reimbursement Form

OneExchange from Towers Watson

Mail: P.O. Box 981156, El Paso, TX 79998-1156 Fax: 1-844-930-0236

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
New	*Self*	*Medicare Part B*	*1/1/2016*	*12/31/2016*	*$XXX.XX*

③ 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 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 OneExchange within a suitable time period.

Account Holder Signature

Date

④ To qualify for your reimbursement you must provide a third party document that includes the information to the right.

Please CHECK ☑ Each Reimbursement Request Qualification as you complete them.

☑ **Does your documentation cover these items**

- ☐ Covered Participant's Name (John Doe)
- ☐ Premium Type (e.g., Medical)
- ☐ Date of Service (01/01/2016 thru 12/31/2016)
- ☐ Monthly Amount (e.g., $104.90)
- ☐ Name of Provider (e.g., Medicare)

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.

Submit one specialized reimbursement form at the beginning of the year to setup automatic reimbursement for the following twelve months. There will be no need to file a reimbursement request again 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.

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

② **Reimbursement Request Information:** This section must be completed with a line for each premium reimbursement requested.

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: Refer to your Eligible Expense Insert (e.g., Medical).

Start Date: This is usually January 1st of each new year or the effective date of the coverage period, such as when a participant becomes Medicare-eligible.

End Date: This is usually December 31st, or could be earlier if there is a death of a covered participant.

Monthly Amount: This amount must match the amount on the supporting document.

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

④ **Documenting Your Premium Reimbursement Request:** All premium reimbursement requests require third party documentation showing each item below:

- ☐ Covered Participant's Name (John Doe)
- ☐ Premium Type (e.g., Medical)
- ☐ Date of Service
  (01/01/2016 thru 12/31/2016)
- ☐ Monthly Amount (e.g., $104.90)
- ☐ Name of Provider (e.g., Medicare)

For Medicare premiums deducted from your Social Security check, use the Social Security Benefit Award 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 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.