# Premium reimbursement form

BENEFIThelp Solutions

To help us process your reimbursement request quickly, please print clearly and return this form as instructed. Please complete all sections of this form. If the application is incomplete or additional information is required, your reimbursement may be delayed. Please do not use a fax cover sheet.

## Section 1 Account holder information

| | | | |
|---|---|---|---|
| * First name | M.I. | * Last name | * Membership identification (or SSN) |
| * Mailing address | *City | * State | * ZIP |
| * Contact number | * Email address | | ☐ New address |
| * Employer | | | * Group identification (if known) |

## Section 2 Reimbursement request

| | | | | |
|---|---|---|---|---|
| 1 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 2 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 3 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| If you need more space, please use page two. Each page will contain its own total. | | | | * Total on this form |

An expense will not be reimbursed until after the service end date. To receive reimbursement your claim must be properly substantiated, you must provide third-party documentation reflecting: (a) name of the insurance company; (b) service start and duration; (c) cost of the premium during the duration; (d) premium description; and (e) all those insured by the policy. If your premium remains unchanged after your first properly substantiated reimbursement, your subsequent reimbursements will require only proof of payment, such as a bank statement or pension stub.

## Section 3 Authorization (please read and sign below)

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for my own or my qualified dependent's personal expenses.
- These services have already been provided and paid for.
- I have not and will not seek reimbursement for this expense from any other plan or party.
- I understand BenefitHelp Solutions reserves the right to deny a claim if I have not provided substantiation and it is actually available or if there is reason to believe the expense is not qualified as defined under the conditions in my Summary Plan Document.

| | |
|---|---|
| * Employee signature<br>X | * Signature date |

**Ready to submit? Mail, fax or submit this form online to BenefitHelp Solutions.**

**Mail: BenefitHelp Solutions, PO Box 67230, Portland, OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com**
**Questions? Contact BenefitHelp Solutions at 888-398-8057.**

## Additional reimbursement requests

### Account holder information

| * First name | M.I. | * Last name | * Membership identification |
|---|---|---|---|
| | | | |
| * Employer | | | * Group identification (if known) |
| | | | |

### Reimbursement request

| | | | | |
|---|---|---|---|---|
| 4 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 5 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 6 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 7 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 8 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 9 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 10 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 11 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |
| 12 | * Name of dependent or self | | * Service start date (MM/DD/YY) | * Service end date (MM/DD/YY) |
| | * Name of insurance provider | Insurance type description | | * Amount requested |

| | |
|---|---|
| If you need more space, please use additional pages. Each page will contain its own total. Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. | * Total on this form |

An expense will not be reimbursed until after the service end date. To receive reimbursement your claim must be properly substantiated, you must provide third-party documentation reflecting: (a) name of the insurance company; (b) service start and duration; (c) cost of the premium during the duration; (d) premium description; and (e) all those insured by the policy. If your premium remains unchanged after your first properly substantiated reimbursement, your subsequent reimbursements will require only proof of payment, such as a bank statement or pension stub.