Automatic Premium Reimbursement

Use this form to set up a recurring reimbursement for your eligible premiums



Claims-eligible participants who are actively-employed and receiving monthly employer contributions must have a minimum account balance of \$2,000 to begin/renew an automatic premium reimbursement.

Skip this form! Log in at hraveba.org and submit your request online.

Submit paper forms to: claims@hraveba.org | HRA VEBA Plan, PO Box 80587, Seattle, WA 98108 | 206-577-3020 fax

Make sure your documentation has everything we need!

The documentation you submit needs to contain all four of the following:

- 1. Name of covered individual(s):
- 2. Coverage period or effective date;
- 3. Name of insurance carrier; and
- Premium amount.

Common forms of documentation include your statement of insurance, open enrollment notice, or premium billing statement. If you are requesting reimbursement for tax-qualified long-term care insurance premiums, be sure to include a copy of your policy's Declarations page. The Declarations page usually contains confirmation that the policy is tax-qualified.

Is my premium eligible?

The below list of qualified premiums is not a complete list, but it does contain many examples of the types of premiums eligible for reimbursement.

- Medical*
- Dental
- Vision

- Medicare
- · Medicare supplement plans
- TRICARE premiums (medical and dental plans)

As a reminder, premiums are not eligible for reimbursement if they are:

- Paid by an employer:
- 2. Deducted pre-tax through a Section 125 cafeteria plan:
- 3. Eligible for pre-tax deduction from your (the participant's) paycheck through your employer's Section 125 cafeteria plan; or
- 4. Subsidized by the premium tax credit.

What should I do next?

- · When your premium amount(s) change or stop, it is your responsibility to notify us to adjust or cancel your automatic premium reimbursement. Failure to update this information may result in your reimbursement(s) being cancelled and/or excess reimbursement amounts being reported as taxable income.
- Be sure to notify us if your direct deposit information or mailing address changes.

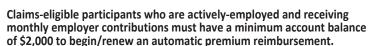
Go Green! Sign up for e-communication and avoid the paper clutter. Make your election online. Log in at HRAveba.org and click My Profile to update your Account Preferences.

Long-term care (tax-qualified; subject to IRS limits)

^{*} Includes marketplace exchange premiums that are not or will not be subsidized by the premium tax credit.

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PARTICIPANT ACCOUNT AND CONTAC		
	T INFORMATION	
	omatic reimbursement will be taken from the a	nt number of the account from which you want you account with the earliest claims-eligibility date. Al nt request.
ACCOUNT NUMBER or SSN DATE OF	BIRTH mm / dd / yyyy	
LAST NAME	FIRST NAME	M.I.
MAILING ADDRESS	CITY	STATE ZIP
AREA CODE and PHONE NUMBER EMAIL ADDRESS	6 (use home or personal email address)	
GO GREEN! Sign up for e-communication and a update your Account Preferences.	void the paper clutter. Make your election online. Lo	g in at HRAveba.org and click My Profile to
IMPORTANT: Have you previously separated or	retired from the employer that made or is makin	ng contributions to this account?
NO DATE OF SEPARATION or RETIREMENT m	m / dd / yyyy EMPLOYER NAME	
CERTIFICATIONS: READ BEFORE SU	BMITTING	
The following certification applies only to major m		
Any major medical premium was <u>either</u> (a) for a market coverage, <u>or</u> (2) incurred while you were s AUTOMATIC PREMIUM REIMBURSEN	separated or retired (not employed or re-employed) w	age provided through an employer) and not for individua
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Any major medical premium was either (a) for a market coverage, or (2) incurred while you were standard to coverage, or (2) incurred while you were standard to cover a coverage. AUTOMATIC PREMIUM REIMBURSEN This is a: NEW request CHANGE to existing reimbursement Amount of each reimbursement: NEW AMOUNT OLD AMOUNT (If this is a change) Is the policy in your name? YES NO NAME DIRECT DEPOSIT ENROLLMENT (RECO	n employer-sponsored group health plan (for covera separated or retired (not employed or re-employed) w ### ### ### ### ### ### ### ### ###	Due date of first reimbursement: (To occur on time, request must be received at least 10 days prior to due date) 1st or 15th day of the month Please make my first reimbursement retroactive to my requested due date, if the due date is in the past, or if this request is not received in time. s), please list his/her name, Social Security number or POLICY NUMBER DATE OF BIRTH Sample check