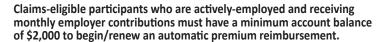
# Automatic Premium Reimbursement

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





### **Skip this form!** Log in at **veba.org** and submit your request online.

Submit paper forms to: claims@veba.org | 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
- Long-term care (tax-qualified; subject to IRS limits)
- 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 veba.org and click My Profile to update your Account Preferences.

<sup>\*</sup> Includes marketplace exchange premiums that are not or will not be subsidized by the premium tax credit.

# **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.



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PARTICIPANT ACCOUNT AND CONTACT	T INFORMATION		
If you are claims-eligible under more than one parautomatic reimbursement. Otherwise, your auto information in this section is required to proc	matic reimbursement will be taken from the	account with the earliest cla	
ACCOUNT NUMBER or SSN DATE OF E	BIRTH mm / dd / yyyy		
LAST NAME	FIRST NAME		M.I.
MAILING ADDRESS	CITY	STA	ATE ZIP
AREA CODE and PHONE NUMBER EMAIL ADDRESS	(use home or personal email address)		
GO GREEN! Sign up for e-communication and av Account Preferences	oid the paper clutter. Make your election online. Lo	og in at <b>veba.org</b> and click <b>My</b> l	Profile to update your
IMPORTANT: Have you previously separated or  ☐ YES ☐ NO ☐ DATE OF SEPARATION or RETIREMENT mn		ng contributions to this acco	ount?
CERTIFICATIONS: READ BEFORE SUI			
To get a current copy of the Plan Summary, log customercare@veba.org or 1-888-828-4953.  The following certification applies only to major metal.  • Any major medical premium was either (a) for an market coverage, or (2) incurred while you were seen as the property of the plan Summary.	edical premiums. It does not apply to dental, vi	sion, and tax-qualified long-te	erm care premiums:  yer) and not for individual
AUTOMATIC PREMIUM REIMBURSEM	ENT INFORMATION		
This is a: NEW request CHANGE to existing reimbursement  Amount of each reimbursement:  NEW AMOUNT OLD AMOUNT (If this is a change)  \$	Frequency: Monthly Quarterly  BEGIN mm / yyyy:  END mm / yyyy: (optional*)  *If you do not enter an end date, your reimbursement will continue until you make a change or your account runs out.	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.	
Is the policy in your name? If reimbursement is policy number, and NO		r POLICY NUMBER	cial Security number or
Direct deposit is faster and more convenient that supersede any previous direct deposit enrollment.	n waiting to receive paper check reimbursem		you provide below will
<ul> <li>New request</li> <li>Use direct deposit already on file</li> </ul> NAME OF BANK OR CREDIT U A DIGIT POUTING NUMBER OF BANK OR CREDIT U		Memo	76543210·   1001
9-DIGIT ROUTING NUMBER (se	ee sample check) ACCOUNT NUMBER (do not include check number	9-digit routing/transit number	Account number Check number