Retiree Premium Reimbursement Program
Retiree Premium Reimbursement Request Form

Spending Account Processing

Your Company Name/Plan Name:______________________________
(Must be completed for your reimbursement request to be processed.)

INSTRUCTIONS

- ***Go Paperless!*** You won't need to complete paper forms anymore. Just submit claims online!
- Fill out separate claim forms for account holder and spouse. It is **MANDATORY** that the **Spouse** always use the Account Holder's UMI (unique identifier) and indicates their relationship as "spouse" when filling out the claim form. The Subscriber should enter their UMI and indicate their relationship as "self."
- Each expense item must be accompanied by a copy of a receipt. Each receipt must show **coverage period, and the total premium expenses and type. Canceled checks will be accepted.** Please retain your original receipts and reimbursement requests filed for your records.
- All information will be protected and maintained as required by law.

Please fax or mail your completed reimbursement request to:

Fax Number: 1-866-228-9417
Spending Account Processing
PO Box 25173
Lehigh Valley, PA 18002-5173

ACCOUNT HOLDER INFORMATION

Subscriber's UMI (unique identifier):		E-Mail Address:	

RETIREE PREMIUM REIMBURSEMENT REQUEST

Coverage Start Date	Coverage End Date	Participant Name	Relationship to Account Holder, i.e. self or spouse	Total Premium Charged	Type of Premium, i.e. medical, dental, vision

Total Reimbursement Requested $ ____________________

CERTIFICATION AND DATE

I certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the program, and that these expenses have not been reimbursed or are not reimbursable under any other plan/program. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I agree to abide by the terms of the program and have read the information on this form.

Signature of Participant:		**Date:**	
(Please print the information below.)			
Name:		Daytime Phone No.:	( )
Relationship (Indicate "Subscriber" or "Spouse")			
Mailing Address:			
City:		State:	
Zip Code:			